Blue Cross Blue Shield/Blue Care Network of Michigan
Medication Authorization Request Form

Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

This form is to be used by participating physicians to obtain coverage for **drugs covered under the medical benefit**. For commercial members only, please complete this form and submit via fax to 1-877-325-5979. If you have any questions regarding this process, please contact BCBSM Provider Relations and Servicing or the Medical Drug Helpdesk at 1-800-437-3803 for assistance.

PATIENT INFORMATION		PHYSICIAN INFORMATION
Name		**Name**
ID Number		**Specialty**
D.O.B.	_____/_____/_____ MM/DD/YYYY ❑Male ❑Female	**Address**
Diagnosis		**City /State/Zip**
Drug Name	**Tysabri**	**Phone:** **Fax:**
Dose and Quantity		**NPI**
Directions		**Contact Person**
Date of Service(s)		**Contact Person** **Phone / Ext.**

STEP 1: DISEASE STATE INFORMATION

Required Demographic Information:

Patient Weight: _____*kg*

Patient Height: _____*ft* _____*inches*

Will the provider be administering the medication to the FEP member within the health plan's geographic service area?

❑ Yes ❑ No *If No, a prior authorization is not required through this process.*

Prior authorizations are required for FEP members that will be serviced by a provider within the health plan's geographic service area. If you are not a provider in the geographic service area, please contact the health plan for questions regarding the FEP member's benefit requirements.

Is this member's FEP coverage primary or secondary coverage?

❑ If primary, continue with question set.

❑ If secondary, **an authorization is not needed through this process. Please contact the member's primary coverage for determination of benefit and additional information.**

Site of Care:

A. At what location will the member be receiving the requested medication?

❑ Physician's office, home infusion, non-hospital affiliated ambulatory infusion center.

❑ Outpatient hospital infusion center. Please provide the name of the infusion center and rationale why the patient must receive this medication in a hospital outpatient setting. _____

_____

❑ Other. Please specify. _____

Criteria Questions:

1. Will the patient be given live vaccines while on this therapy? ❑Yes ❑No
2. Is the patient enrolled in and meeting all conditions of the TOUCH Prescribing Program? ❑Yes ❑No
3. Has the patient been on Tysabri therapy continuously for the last **3 months**, excluding samples?

❑ **NO** – this is **INITIATION** of therapy, please answer the following questions:

❑ **Multiple Sclerosis (MS)**

i. Does the patient have any of the following diagnoses listed below:

❑ Active secondary progressive multiple sclerosis ❑ Clinically isolated syndrome (CIS)

❑ Relapsing multiple sclerosis (RMS) ❑ Relapsing-remitting multiple sclerosis (MS)

❑ Other type ***(please specify)***:_____

ii. Has the patient failed to respond adequately to another multiple sclerosis therapy?

❑Yes ❑No*

If NO, is the patient intolerant or have a contraindication to another multiple sclerosis therapy?

❑Yes ❑No

iii. Will the Tysabri be used as monotherapy? ❑Yes ❑No

- ❑ **Crohn's Disease**
  - i. Does the patient have moderately to severely active Crohn's disease? ❑Yes ❑No
  - ii. Has the patient had an inadequate response to conventional Crohn's disease therapy and TNF inhibitors? ❑Yes ❑No*
    ***If NO,** is the patient unable to tolerant or have a contraindication to conventional Crohn's disease therapy and TNF inhibitors? ❑Yes ❑No
  - iii. Will Tysabri be used in combination with immunosuppressants or TNF inhibitors? ❑Yes ❑No

- ❑ **Other diagnosis *(please specify):*** _____
  - i. Does the patient currently have or has had progressive multifocal leukoencephalopathy (PML) in the past? ❑Yes ❑No
  - ii. Will the patient be monitored for any signs or symptoms that might be suggestive of PML and therapy held if they develop? ❑Yes ❑No
  - iii. Does the patient have significantly compromised immune system function? ❑Yes ❑No

- ❑ **YES** - this is a renewal PA for the **CONTINUATION** of therapy, please answer the following questions:
  - a. What is the patient's **diagnosis**?
    - ❑ **Multiple Sclerosis (MS)**
      - i. Does the patient have any of the following diagnoses listed below:
        - ❑ Active secondary progressive multiple sclerosis
        - ❑ Clinically isolated syndrome (CIS)
        - ❑ Relapsing multiple sclerosis (RMS)
        - ❑ Relapsing-remitting multiple sclerosis (MS)
        - ❑ Other type ***(please specify)***:_____
      - ii. Will Tysabri be used as monotherapy? ❑Yes ❑No
    - ❑ **Crohn's Disease**
      - i. Will Tysabri be used in combination with immunosuppressants or TNF inhibitors? ❑Yes ❑No
      - ii. Did the patient have a therapeutic benefit after 12 weeks of induction therapy? ❑Yes ❑No
    - ❑ **Other diagnosis *(please specify):***_____
  - b. Does the patient have progressive multifocal leukoencephalopathy (PML)? ❑Yes ❑No
  - c. Is the patient receiving concurrent therapy with systemic corticosteroids? ❑Yes ❑No
  - d. Does the patient have evidence of jaundice or liver injury? ❑Yes ❑No
  - e. Has the patient developed an opportunistic infection? ❑Yes ❑No
  - f. Has the patient developed herpes infections? ❑Yes ❑No

Chart notes are required for the processing of all requests. Please add any other supporting medical information necessary for our review **(required)**

Coverage will not be provided if the prescribing physician's signature and date are not reflected on this document.

❑ Request for expedited review: I certify that applying the standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function

Physician's Name	**Physician Signature**	**Date**
Step 2: Checklist	❑ Form Completely Filled Out ❑ Provide chart notes	❑ Attach test results
Step 3: Submit	**By Fax: BCBSM Specialty Pharmacy Mailbox** **1-877-325-5979**	**By Mail: BCBSM Specialty Pharmacy Program** **P.O. Box 312320, Detroit, MI 48231-2320**