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. ☐Male ☐Female	**Address**
Diagnosis	**City /State/Zip**
Drug Name **ULTOMIRIS**	**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. Has the patient been on Ultomiris continuously for the last **4 months**, excluding samples? ***Please select answer below:***

   ❑ **YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the questions on the **Continuation section.**

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

2. Has or will the patient be vaccinated against Neisseria meningitidis at least 2 weeks prior to initiating therapy? ❑Yes ❑No*

   If NO, is urgent Ultomiris therapy indicated for this patient (e.g., the risks of delaying treatment with Ultomiris outweigh the risk of developing a meningococcal infection)? ❑Yes ❑No

3. Is the prescriber enrolled in the Ultomiris REMS program? ❑Yes ❑No

4. What is the patient's diagnosis?

   ❑Atypical Hemolytic Uremic Syndrome (aHUS)

   a. Does the patient have a documented baseline value for serum lactate dehydrogenase (LDH)? ❑Yes ❑No

   b. Does the patient have Shiga toxin E. coli related hemolytic uremic syndrome (STEC-HUS)? ❑Yes ❑No

   c. Will Ultomiris be used in combination with another Prior Authorization (PA) medication for atypical hemolytic uremic syndrome such as Soliris (eculizumab)? ❑Yes* ❑No

   If YES, specify the medication: _____

   ❑Generalized Myasthenia Gravis (gMG)

   a. Does the patient have a positive serologic test for anti-AChR antibodies? ❑Yes ❑No

   b. What is the patient's MGFA (Myasthenia Gravis Foundation of America) clinical classification? ***Select classification below:***

   ❑Class I ❑Class II to IV* ❑Class V ❑Unknown

   If Class II to IV, does the patient have a documented baseline *MG-Activities of Daily Living (MG-ADL) total score greater than or equal to 6? ❑Yes ❑No

   ****MG-ADL*: http://c.peerview.com/inReview/programs/150204324/downloads/PVI_practiceaids_RMU.pdf**

   c. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to an acetylcholinesterase inhibitor? ❑Yes ❑No

   d. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to at least one immunosuppressive therapy either in combination or as monotherapy, such as: azathioprine, cyclosporine, mycophenolate mofetil, tacrolimus, methotrexate, or cyclophosphamide? ❑Yes ❑No

   e. Will Ultomiris be used in combination with another Prior Authorization (PA) C5 complement inhibitor for generalized myasthenia gravis such as Soliris (eculizumab)? ❑Yes* ❑No

   If YES, specify the medication: _____

   ❑Paroxysmal Nocturnal Hemoglobinuria (PNH)

   a. Does the patient have a documented baseline value for serum lactate dehydrogenase (LDH)? ❑Yes ❑No

   b. Will Ultomiris be used in combination with another Prior Authorization (PA) medication for paroxysmal nocturnal hemoglobinuria such as Empaveli (pegcetacoplan) or Soliris (eculizumab)? ❑Yes* ❑No

   If YES, specify the medication: _____

   ❑Neuromyelitis optica spectrum disorder (NMOSD)

   a. Is the patient anti-aquaporin-4 (AQP4) antibody positive? ❑Yes ❑No

   b. Will this medication be used in combination with another Prior Authorization (PA) C5 complement inhibitor for neuromyelitis optica spectrum disorder (NMOSD)? ❑Yes* ❑No

   If YES, specify the medication: _____

   ❑None of the above

CONTINUATION OF THERAPY (PA RENEWAL)
Ultomiris (ravulizumab-cwvz)

NOTE: Form must be completed in its **entirety** for processing

1. Has the patient been on Ultomiris continuously for the last **4 months**, excluding samples? ***Please select answer below:***
   - ❑ **NO** – this is **INITIATION** of therapy, please answer the questions on the **Initiation section.**
   - ❑ **YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the questions below:
2. What is the patient's diagnosis?
   - ❑Atypical Hemolytic Uremic Syndrome (aHUS)
     a. Has the patient had a decrease in serum lactate dehydrogenase (LDH) from pretreatment baseline? ❑Yes ❑No
     b. Does the patient have Shiga toxin E. coli related hemolytic uremic syndrome (STEC-HUS)? ❑Yes ❑No
     c. Will Ultomiris be used in combination with another Prior Authorization (PA) medication for atypical hemolytic uremic syndrome such as Soliris (eculizumab)? ❑Yes* ❑No
     ***If YES,** specify the medication: _____
   - ❑Generalized Myasthenia Gravis (gMG)
     a. Is there a documented decrease of the *MG-Activities of Daily Living (MG-ADL) total score from baseline of greater than or equal to 2 points? ❑Yes ❑No
     ***MG-ADL**: http://c.peerview.com/inReview/programs/150204324/downloads/PVI_practiceaids_RMU.pdf
     b. Will Ultomiris be used in combination with another Prior Authorization (PA) C5 complement inhibitor for generalized myasthenia gravis such as Soliris (eculizumab)? ❑Yes* ❑No
     ***If YES**, specify the medication: _____
   - ❑Paroxysmal Nocturnal Hemoglobinuria (PHN)
     a. Has the patient had a decrease in serum lactate dehydrogenase (LDH) from pretreatment baseline? ❑Yes ❑No
     b. Will Ultomiris be used in combination with another Prior Authorization (PA) medication for paroxysmal nocturnal hemoglobinuria such as Empaveli (pegcetacoplan) or Soliris (eculizumab)? ❑Yes* ❑No
     ***If YES,** specify the medication: _____
   - ❑Neuromyelitis optica spectrum disorder (NMOSD)
     a. Has the patient had fewer relapses while on Ultomiris therapy? ❑Yes ❑No
     b. Will this medication be used in combination with another Prior Authorization (PA) C5 complement inhibitor for neuromyelitis optica spectrum disorder (NMOSD)? ❑Yes* ❑No
     ***If YES,** specify the medication: _____
   - ❑None of the above
3. Has the patient experienced unacceptable toxicity while on Ultomiris therapy? ❑Yes ❑No
4. Is the prescriber enrolled in the Ultomiris REMS program? ❑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**