Blue Care Network of Michigan Medication Authorization Request Form

Lutathera® (lutetium Lu 177 dotatate) HCPCS CODE: A9699, C9031

This form is to be used by participating physicians to obtain coverage for Lutathera. 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 BCN Provider Relations and Servicing or the Medical Drug Helpdesk at 1-800-437-3803 for assistance.

Blue Care Network of Michigan

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PATIENT INFORMATION	PHYSICIAN INFORMATION
Name	**Name**
ID Number	**Specialty**
D.O.B. ☐Male ☐Female **Pt weight (in kg)**	**Address**
Diagnosis	**City /State/Zip**
Drug Name	**Phone/Fax: P**: ( ) - **F**: ( ) -
Dose and Quantity	**NPI**
Directions	**Contact Person**
Date of Service(s)	**Contact Person Phone / Ext.**

STEP 1: DISEASE STATE INFORMATION

1. Is this request? ☐ Initiation ☐ Continuation *Date patient started therapy:* _____

2. **Initiation AND Continuation of therapy:**
   a. What is the patient's diagnosis?
      ☐ Somatostatin receptor-positive gastroenteropancreatic neuroendocrine tumors (GEP-NETs), including foregut, midgut, and hindgut neuroendocrine tumors
      ☐ Other: _____
   b. What other medication has the patient received for their condition? Please: list_____
      i. Please describe the response to previous therapies:
      _____
   c. Will the patient be receiving any other treatment for the listed condition while on Lutathera? Please list:
      _____

3. **Continuation of therapy**:
   a. Has the patient progressed while on Lutathera therapy? ☐ yes ☐ no
   b. How has the patient's condition changed while on Lutathera therapy?
      ☐ Improved: Please describe: _____
      ☐ Stable: please describe: _____
      ☐ Worsened; Please describe: _____
      ☐ Other; Please describe: _____

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

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 patient or the patient's ability to regain maximum function

Physician's Name **Physician Signature** **Date**

Step 2: Checklist	☐ Form Completely Filled Out ☐ Attached chart notes	☐ Attached test results
Step 3: Submit	**By Fax: BCN Specialty Pharmacy Mailbox 1-877-325-5979**	**By Mail: BCN Specialty Pharmacy Program P.O. Box 312320, Detroit, MI 48231-2320**