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	**Crysvita**	**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. What is the patient's diagnosis?

❑FGF23-related hypophosphatemia in tumor-induced osteomalacia (TIO)

❑X-linked dominant hypophosphatemic rickets

❑X-linked hypophosphatemia (XLH)

❑X-linked vitamin D-resistant rickets

❑Other ***(please specify)***: _____

2. Has the patient been on this medication continuously for the last **6 months** excluding samples? ❑Yes ❑No*

- ***If NO,*** please answer the following questions:

a. **FGF23-related hypophosphatemia in Tumor-Induced Osteomalacia (TIO) Diagnosis:** Is the patient's diagnosis associated with phosphaturic mesenchymal tumors that cannot be curatively resected or localized? ❑Yes ❑No

b**. X-linked hypophosphatemia, X-linked dominant hypophosphatemic rickets, X-linked vitamin D-resistant rickets Diagnoses**: Has the diagnosis been confirmed by genetic testing of PHEX (phosphate regulating gene with homology to endopeptidases located on the X chromosome) mutation in the patient? ❑Yes ❑No

c. Is the patient currently taking any oral phosphate or active vitamin D analog supplementation? ❑Yes* ❑No

If YES, will the patient discontinue the oral phosphate or vitamin D analog supplementation at least one week prior to starting therapy with Crysvita? ❑Yes ❑No

d. Is the fasting serum phosphorus within or above the normal range for the patient's age? ❑Yes ❑No

3. Does the prescriber agree to measure serum phosphorous throughout therapy and withhold the medication when the serum phosphorus is above the reference range for the patient's age? ❑Yes ❑No

4. Does the patient have an estimated glomerular filtration rate (eGFR) less than 30 milliliters per minute per 1.73 square meter (mL/min/1.73 m^2)? ❑Yes ❑No

5. Will Crysvita be administered by a healthcare provider? ❑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**