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	**EYLEA, EYLEA HD**	**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 questionset.

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

Criteria Questions:

Please select medication:	**❑Eylea (aflibercept)**	**❑Eylea HD (aflibercept)**

1. Has the patient been on this medication continuously for the last **6 months**, excluding samples? ***Please select answer below:***
   - ❑ **NO** – this is **INITIATION** of therapy, please answer the following question:
     a. What is the patient's diagnosis?
     - ❑Diabetic Macular Edema (DME) **OR** ❑Diabetic Retinopathy (DR)
       i. Is there documentation of a baseline visual acuity test? ❑Yes ❑No
     - ❑Macular edema following Retinal Vein Occlusion (RVO)
       i. Is there documentation of a baseline visual acuity test? ❑Yes ❑No
     - ❑Neovascular (wet) Age-related Macular Degeneration (AMD)
       i. Is there documentation of a baseline visual acuity test? ❑Yes ❑No
     - ❑Retinopathy of Prematurity (ROP)
     - ❑None of the above
   - ❑ **YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:
     a. What is the patient's diagnosis?
     - ❑Diabetic Macular Edema (DME) **OR** ❑Diabetic Retinopathy (DR)
       i. Has the patient demonstrated a positive clinical response to therapy (e.g., improvement or maintenance in best corrected visual acuity [BCVA] or visual field, or a reduction in the rate of vision decline or the risk of more severe vision loss)? ❑Yes ❑No
     - ❑Macular edema following Retinal Vein Occlusion (RVO)
       i. Has the patient demonstrated a positive clinical response to therapy (e.g., improvement or maintenance in best corrected visual acuity [BCVA] or visual field, or a reduction in the rate of vision decline or the risk of more severe vision loss)? ❑Yes ❑No
     - ❑Neovascular (wet) Age-related Macular Degeneration (AMD)
       i. Has the patient demonstrated a positive clinical response to therapy (e.g., improvement or maintenance in best corrected visual acuity [BCVA] or visual field, or a reduction in the rate of vision decline or the risk of more severe vision loss)? ❑Yes ❑No
     - ❑Retinopathy of Prematurity (ROP)
       i. Has the patient demonstrated a positive clinical response to therapy (e.g., no clinically significant reactivations of ROP)? ❑Yes ❑No
     - ❑None of the above
2. Does the patient have either an ocular or periocular infection? ❑Yes ❑No
3. Does the patient have active intraocular inflammation? ❑Yes ❑No
4. Will this medication be used in combination with other *vascular endothelial growth factor (VEGF) inhibitors for ocular indications? ❑Yes* ❑No

If YES, please specify the medication: _____

VEGF Inhibitors: Avastin (bevacizumab), Beovu (brolucizumab-dbll), Eylea/Eylea HD (aflibercept), Lucentis (ranibizumab), Susvimo (ranibizumab), Vabysmo (faricimab-svoa)

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**