

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



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 Levoleucovorin, Khapzory, Fusilev		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.**

Criteria Questions:

1. Is leucovorin an appropriate and available treatment option at this time?

☐ Yes, *Continue to 2*

☐ No, *Continue to 2*

2. What is the reason for requesting levoleucovorin/Fusilev/Khapzory?

☐ Combination therapy with fluorouracil based chemotherapy regimens, *No further questions*

☐ Rescue treatment after high-dose methotrexate therapy, *No further questions*

☐ Treatment of folate antagonist overdosage, *No further questions*

☐ Treatment of impaired methotrexate elimination, *No further questions*

☐ Other, please specify. _____, *No further questions*

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