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	**Hemlibra**	**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.**

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:

What is the ICD-10 code? _____

1. What is the diagnosis?

❒ Hemophilia A (congenital factor VIII deficiency), *Continue to 2*

❒ Acquired hemophilia A, *Continue to 2*

❒ Other, please specify. _____, *Continue to 2*

2. Is the requested medication prescribed by or in consultation with a hematologist?

❒ Yes, *Continue to 3*

❒ No, *Continue to 3*

3. Is the request for continuation of therapy?

❒ Yes, *Continue to 4*

❒ No, *Continue to 6*

4. Is the patient experiencing benefit from therapy (e.g., reduced frequency or severity of bleeds)? ***ACTION REQUIRED***: If Yes, attach supporting chart note(s).
❒ Yes, *Continue to 5*
❒ No, *Continue to 5*

5. Will the patient use the requested medication for prophylactic use in combination with factor VIII products (e.g., Advate, Adynovate, Eloctate, etc.)?
❒ Yes, *Continue to 16*
❒ No, *Continue to 16*

6. Is the requested medication being requested for routine prophylaxis to prevent or reduce the frequency of bleeding episodes?
❒ Yes, *Continue to 7*
❒ No, *Continue to 7*

7. What is the patient's baseline factor VIII assay level (% activity)?
❒ Less than 1% to 5% (moderate or severe disease), *Continue to 11*
❒ Greater than 5% (mild disease), *Continue to 8*

8. Has the patient had an insufficient response to desmopressin?
❒ Yes, *Continue to 11*
❒ No, *Continue to 9*

9. Is there a clinical reason for not trying desmopressin first?
❒ Yes, *Continue to 10*
❒ No, *Continue to 10*

10. What is the reason? Please indicate the clinical reason for not trying desmopressin first.
❒ Age less than 2 years, *Continue to 11*
❒ Pregnancy, *Continue to 11*
❒ Fluid/electrolyte imbalance, *Continue to 11*
❒ High risk for cardiovascular or cerebrovascular disease (especially the elderly), *Continue to 11*
❒ Predisposition to thrombus formation, *Continue to 11*
❒ Trauma requiring surgery, *Continue to 11*
❒ Life-threatening bleed, *Continue to 11*
❒ Contraindication or intolerance to desmopressin, *Continue to 11*
❒ Stimate Nasal Spray is unavailable due to backorder/shortage issues (where applicable), *Continue to 11*
❒ Other, please specify. _____, *Continue to 11*

11. Will prophylactic use of factor VIII products (e.g., Advate, Adynovate, Eloctate) be discontinued after the first week of starting therapy with the requested medication?
❒ Yes, *Continue to 12*
❒ No, *Continue to 12*

12. What is the patient's body weight in kilograms?
❒ Any weight; please specify: _____, *Continue to 13*
❒ Unknown, *Continue to 13*

13. What is the prescribed induction dose in milligrams (mg)?
❒ Any dose; please specify: _____, *Continue to 14*
❒ Unknown, *Continue to 14*

14. Is the prescribed frequency more frequent than once weekly for the first 4 weeks?
❒ Yes, *Continue to 15*
❒ No, *Continue to 15*

15. Does the prescribed induction dose exceed 3 mg/kg subcutaneously for the first 4 weeks?
Please calculate dose from responses to questions #12 and #13.
❒ Yes, *Continue to 17*
❒ No, *Continue to 17*

16. What is the patient's body weight in kilograms (kg)?
❒ Any weight; please specify: _____, *Continue to 17*
❒ Unknown, *Continue to 17*

17. What is the prescribed maintenance dose in milligrams (mg)?
❒ Any dose; please specify: _____, *Continue to 18*
❒ Unknown, *Continue to 18*

18. What is the prescribed frequency for the maintenance dose?
❒ Once every week, *Continue to 19*
❒ Once every two weeks, *Continue to 20*
❒ Once every four weeks, *Continue to 21*
❒ Other, please specify. _____, *No Further Questions*

19. Does the prescribed maintenance dose exceed 1.5 mg/kg?
Please calculate dose from responses to questions #16 and #17.
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

20. Does the prescribed maintenance dose exceed 3 mg/kg?
Please calculate dose from responses to questions #16 and #17.
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

21. Does the prescribed maintenance dose exceed 6 mg/kg?
Please calculate dose from responses to questions #16 and #17.
❒ Yes, *No Further Questions*
❒ No, *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**