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	**Avsola, Inflectra, Infliximab, Remicade, Renflexis**	**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:

Please select medication:

❒**Infliximab**
❒**Remicade (infliximab)**
❒**Avsola (infliximab-axxq)**
❒**Inflectra (infliximab-dyyb)**

1. Has the patient been on treatment with the requested agent continuously for the last **4 months** for **Rheumatoid Arthritis OR** for for the last **3 months** for **ALL other diagnoses** excluding samples?
   ❒**YES** – this is a PA renewal for **CONTINUATION** of therapy, **please answer the questions on continuation section.**
   ❒**NO** – this is **INITIATION** of therapy, please answer the questions below:

2. Has the patient had a TB test prior to initiating therapy? ❒Yes***** ❒No
   ****If YES***, does the patient have an active or latent tuberculosis infection? ❒Active TB ❒Latent TB***** ❒Test was negative

3. **If Latent TB Infection**: Has the patient started treatment for the infection prior to the use of this medication? ❒Yes ❒No

4. Does the patient have any active infections? ❒Yes ❒No

5. Is the patient at risk for hepatitis B virus (HBV) infection? ❒Yes***** ❒No
   ****If YES***, has hepatitis B virus (HBV) infection been ruled out or has the patient already started treatment for HBV infection? ❒Yes ❒No

6. Will the patient be given live vaccines while on this therapy? ❒Yes ❒No

7. **Requests for Avsola (infliximab-axxq) or Renflexis (infliximab-abda):** Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to **ONE** of the following medications: Inflectra, Infliximab, or Remicade? ❒Yes ❒No

9. Will the requested medication be used in combination with another biologic *****DMARD or targeted synthetic DMARD? ❒Yes***** ❒No
   ****If YES***, please specify the medication: _____
   ****DMARDs: Actemra, Avsola, Cimzia, Cosentyx, Enbrel, Entyvio, Humira or a Humira biosimilar, Ilumya, Inflectra, Kevzara, Kineret, Olumiant, Orencia, Otezla, Remicade, Renflexis, Riabni, Rinvoq, Rituxan, Ruxience, Siliq, Simponi/Simponi Aria, Skyrizi, Spevigo, Sotyktu, Stelara, Taltz, Tremfya, Truxima, Xeljanz***

3. What is the patient's diagnosis?
   ❒Behcet's syndrome ❒Sarcoidosis ❒ Hidradenitis suppurativa (HS)
   ❒Pyoderma gangrenosum ❒Takayasu's arteritis ❒ Granulomatosis w/polyangiitis (Wegener's granulomatosis)
   ❒Ankylosing Spondylitis (AS) / axial spondyloarthritis
   a. Is the patient's condition active? ❒Yes ❒No
   b. Has the patient had an inadequate response to at least two non-steroidal anti-inflammatory drugs (NSAIDs) over a four-week period in total at the maximum recommended or tolerated anti-inflammatory doses? ❒Yes ❒No

   ❒Crohn's Disease (CD)
   a. Does the patient have moderate to severely active Crohn's disease? ❒Yes ❒No
   b. **Age 6-17**: Will the patient be current on all vaccinations prior to initiating therapy? ❒Yes ❒No
   c. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to conventional therapy for Crohn's disease (CD)? ❒Yes ❒No

   ❒Juvenile Idiopathic Arthritis (JIA)
   a. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to at least a 3 month trial of a self-injectable TNF inhibitor for juvenile idiopathic arthritis (JIA)? ❒Yes ❒No

   ❒Plaque Psoriasis (PsO)
   a. Does the patient have severe plaque psoriasis that covers at least 5% of body surface area (BSA) or affects crucial body areas such as hands, feet, face, neck, scalp, genitals/groin, and intertriginous areas? ❒Yes ❒No
   b. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to conventional systemic therapy? ❒Yes***** ***(*If YES, please select one of the following below)*** ❒No
      ❒Inadequate response ❒Intolerance or contraindication ❒Has not tried conventional systemic therapy
   c. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to phototherapy?
      ❒Inadequate response ❒Intolerance or contraindication ❒Has not tried phototherapy

❒Psoriatic Arthritis (PsA)

a. Is the psoriatic arthritis active? ❒Yes ❒No

b. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a 3-month trial of at least one conventional DMARD? ❒Yes ❒No

❒Rheumatoid Arthritis (RA)

a. Does the patient have moderate to severely active rheumatoid arthritis (RA)? ❒Yes ❒No

b. Has the patient had an inadequate response to at least a three-month trial of methotrexate despite adequate dosing (i.e., titrated to 20mg/week)? ❒Yes ❒No*****

****If NO***, does the patient have a contraindication or intolerance to methotrexate? ❒Yes ❒No

c. Does the patient have a contraindication or intolerance to leflunomide? ❒Yes ❒No*****

****If NO***, will the patient receive concurrent therapy with either methotrexate or leflunomide? ❒Yes ❒No

❒Ulcerative Colitis (UC)

a. Does the patient have moderate to severely active ulcerative colitis (UC)? ❒Yes ❒No

b. **Age 6-17**: Will the patient be current on all vaccinations prior to initiating therapy? ❒Yes ❒No

c. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to conventional therapy for ulcerative colitis (UC)? ❒Yes ❒No

❒Uveitis

a. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a trial of immunosuppressive therapy for uveitis ? ❒Yes ❒No

❒Other diagnosis (***please specify***): _____

CONTINUATION OF THERAPY

1. Has the patient been on the requested medication continuously for the last **4 months** for **Rheumatoid Arthritis OR** for the last **3 months** for **ALL other diagnoses**, excluding samples? ***Please select answer below:***
   ❒**YES** - this is a PA renewal for **CONTINUATION** of therapy, please answer the questions below.
   ❒**NO** - this is **INITIATION** of therapy, please answer the questions starting on **initiation section**.

2. What is the patient's diagnosis?
   ❒Ankylosing Spondylitis (AS) / axial spondyloarthritis
   ❒Behcet's syndrome
   ❒Crohn's Disease (CD)
   ❒Hidradenitis suppurativa
   ❒Granulomatosis w/polyangiitis (Wegener's granulomatosis)
   ❒Juvenile Idiopathic Arthritis (JIA)
   ❒Plaque Psoriasis (PsO)
   ❒Psoriatic Arthritis (PsA)
   ❒Pyoderma gangrenosum
   ❒Rheumatoid Arthritis (RA)
   ❒Sarcoidosis
   ❒Takayasu's arteritis
   ❒Ulcerative Colitis (UC)
   ❒Uveitis
   ❒Other diagnosis ***(please specify)***: _____

3. Has the patient's condition improved or stabilized? ❒Yes ❒No

4. Does the patient have any active infections including tuberculosis (TB) and hepatitis B virus (HBV)? ❒Yes ❒No

5. Will the patient be given live vaccines while on this therapy? ❒Yes ❒No

6. Will the requested medication be used in combination with another biologic *****disease-modifying antirheumatic drug **(**DMARD) or targeted synthetic DMARD? ❒Yes***** ❒No
   ****If YES***, please specify: _____
   ****DMARD includes: Actemra, Avsola, Cimzia, Cosentyx, Enbrel, Entyvio, Humira, Ilumya, Inflectra, Kevzara, Kineret, Olumiant, Orencia, Otezla, Renflexis, Riabni, Rinvoq, Rituxan, Ruxience, Siliq, Simponi/Simponi Aria, Skyrizi, Stelara, Taltz, Tremfya, Truxima, and Xeljanz***

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**