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	**Kalbitor**	**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:

1. What is the patient's diagnosis?
   - ❑ Hereditary Angioedema (HAE)
   - ❑ Other diagnosis ***(please specify)*****:** _____
2. Is Kalbitor being used to treat acute attacks or for the routine prevention of hereditary angioedema? ***Please select answer below:***
   - ❑ Acute attacks ❑ Routine prevention
3. Will Kalbitor be administered by a healthcare professional with appropriate medical support to managed anaphylaxis and hereditary angioedema? ❑Yes ❑No
4. Will this medication be used in combination with another agent for treating acute attacks of hereditary angioedema (HAE)? ❑Yes* ❑No

   If YES, specify the medication: _____
5. Has the patient been on Kalbitor continuously for the last **6 months**, excluding samples? ***Please select answer below:***

   ❑ **NO** – this is **INITIATION** of therapy, please answer the following questions:
   a. Does the patient have a normal C1 inhibitor as confirmed by laboratory testing? ***Select answer below:***
      - ❑ **Yes**: Please answer the following questions:
        i. Does the patient have a F12, angiopoietin-1, plasminogen, or kininogen-1 (KNG1) gene mutation as confirmed by genetic testing? ❑Yes ❑No
        ii. Does the patient have a documented family history of angioedema? ❑Yes* ❑No

        If YES, is the angioedema refractory to a trial of high-dose antihistamine such as cetirizine for at least one month? ❑Yes ❑No
      - ❑ **No**: Please answer the following questions:
        i. Does the patient have a C1 inhibitor deficiency or dysfunction as confirmed by laboratory testing? ❑Yes ❑No
        ii. Is the patient's C4 level below the lower limit of normal as defined by the laboratory performing the test? ❑Yes ❑No
        iii. Does the patient have a normal C1-INH antigenic level as defined by the laboratory performing the test? ***Answer below:***
           - ❑ **Yes**: Does the patient have a C1-INH functional level less than 50% or a C1-INH functional level below the lower limit of normal as defined by the laboratory performing the test? ❑Yes ❑No
           - ❑ **No**: Is the patient's C1 inhibitor (C1-INH) antigenic level below the lower limit of normal as defined by the laboratory performing the test? ❑Yes ❑No

   ❑ **YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:
   a. Has the patient experienced a reduction in severity and/or duration of hereditary angioedema attacks? ❑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**