

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



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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	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:

- What is the prescribed drug? ☐ Makena ☐ hydroxyprogesterone caproate
- What is the reason for prescribing the requested medication?
☐ Reduce the risk of preterm birth
☐ Other _____
- What is the ICD-10 code? _____
- Is this a singleton pregnancy? ☐ Yes ☐ No
- Has the patient had a previous spontaneous preterm birth, defined as delivery at less than 37 weeks gestation following preterm labor, preterm rupture of membranes, and cervical insufficiency? ☐ Yes ☐ No
- Was the previous preterm birth also a singleton pregnancy? ☐ Yes ☐ No
- Does the patient have any of the following contraindications to the use of Makena?
☐ Current or history of thrombosis or thromboembolic disorders
☐ Known or suspected breast cancer, other hormone-sensitive cancer, or a history of these conditions
☐ Undiagnosed abnormal vaginal bleeding unrelated to pregnancy
☐ Cholestatic jaundice of pregnancy
☐ Liver tumors, benign or malignant, or active liver disease
☐ Uncontrolled hypertension
☐ None of the above
- Will Makena be initiated between 16 weeks, 0 days to 24 weeks, 6 days gestation? ☐ Yes ☐ No

9. What is the **current** gestational age: _____ weeks _____ days as of _____ date

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

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