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	**OXLUMO**	**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.**

Criteria Questions:

1. What is the patient's diagnosis?
   - ❑Primary hyperoxaluria type 1 (PH1)
   - ❑Other diagnosis ***(please specify)***: _____
2. Has the patient received a liver transplant? ❑Yes ❑No
3. Will the patient be dosed based on actual body weight? ❑Yes ❑No
4. Has the patient been on this medication continuously for the last **6 months** excluding samples? ***Please select answer below***

❑ **NO** – this is **INITIATION** of therapy, please answer the following question:

a. Has the patient's diagnosis been confirmed by identification of biallelic pathogenic variants in alanine: glyoxylate aminotransferase (AGT or AGXT) gene OR liver biopsy demonstrating AGT deficiency? ❑Yes ❑No

b. Does the patient have an elevated urine oxalate excretion level equal to or greater than 0.7 millimoles per 1.73 square meter? ❑Yes ❑No

c. Does the patient have an elevated plasma oxalate concentration level greater than 20 micromoles per liter or greater than 1.76 milligrams per liter? ❑Yes ❑No

d. Does the patient have a urine oxalate excretion to creatinine ratio above age-specific upper limit of normal? ❑Yes ❑No

e. Does the patient have an estimated glomerular filtration rate (eGFR) greater than 30 milliliters per minute per 1.73 square meter? ❑Yes ❑No

f. Does the prescriber agree to monitor urinary oxalate levels? ❑Yes ❑No

g. Is this medication being prescribed by or in consultation with a nephrologist, urologist, geneticist, or any healthcare provider with expertise in treating primary hyperoxaluria type 1? ❑Yes ❑No

❑ **YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:

a. Has the patient had a clinically meaningful response to therapy from pre-treatment baseline? ❑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**