

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 Skyrizi IV	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:

1. Is this request for initiation of therapy with Skyrizi? ☐Yes ☐No
2. Will the patient's initial induction dosing be administered by intravenous infusion at week 0, week 4, and week 8? ☐Yes ☐No
3. What is the patient's diagnosis?
☐Crohn's disease (CD)
 - a. Does the patient have moderately to severely active Crohn's disease (CD)? ☐Yes ☐No
 - b. Does the prescriber agree to administer the initial induction IV infusions within the dose of 600 mg? ☐Yes ☐No☐Ulcerative colitis (UC)
 - a. Does the patient have moderately to severely active ulcerative colitis (UC)? ☐Yes ☐No
 - b. Does the prescriber agree to administer the initial induction IV infusions within the dose of 1200 mg? ☐Yes ☐No☐Other diagnosis (*please specify*): _____
4. Does the prescriber agree to monitor liver enzymes and bilirubin levels for hepatotoxicity? ☐Yes ☐No
5. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to at least one conventional therapy option? ☐Yes ☐No
6. Has the patient been tested for latent tuberculosis (TB)? ☐Yes* ☐No
**If YES*, was the result of the test positive or negative for TB infection? ☐Negative ☐Positive*
**If POSITIVE*, has the patient completed treatment or is the patient currently receiving treatment for latent TB? ☐Yes ☐No
7. Does the patient have any active infections including tuberculosis (TB) or hepatitis B virus (HBV)? ☐Yes ☐No
8. Will the patient be given live vaccines while on Skyrizi? ☐Yes ☐No
9. Will Skyrizi be used in combination with another biologic *disease-modifying antirheumatic drug (DMARD) or targeted synthetic DMARD? ☐Yes* ☐No
**If YES*, please specify medication: _____
**DMARDs: Actemra, Avsola, Cimzia, Cosentyx, Enbrel, Entyvio, Humira, Ilumya, Inflectra, Kevzara, Kineret, Olumiant, Orencia, Otezla, Remicade, Renflexis, Riabni, Rinvoq, Rituxan, Ruxience, Siliq, Simponi/Simponi Aria, Stelara, Taltz, Tremfya, Truxima, and Xeljanz/Xeljanz XR*

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