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	**Spinraza**	**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. What is the patient's diagnosis?
   - ❑ Spinal Muscular Atrophy (SMA)
     - a. Has the patient received the 4 loading doses? ***Please select answer below:***
       - ❑ **NO:** ***Please answer the following questions below:***
         - i. What type of SMA does the patient have?
           - ❑ Type I (infantile onset or Werdnig-Hoffman disease)
           - ❑ Type II (intermediate SMA)
           - ❑ Type III (mild SMA or Kugleber-Welander disease)
           - ❑ Type IV (adult onset SMA)
         - ii. Has the diagnosis been confirmed by genetic testing? ❑ Yes* ❑ No
           **If YES*, did the testing show 5q SMA of ONE of the following:
           Please select one of the following below:
           - ❑ Homozygous gene deletion or mutation
           - ❑ Compound heterozygous mutation
           - ❑ No
         - iii. Has a baseline motor milestone score from one of the following tests: HINE, CHOP-INTEND, Upper Limb Module (ULM) or Hammersmith Functional Motor Scale (HFMS), been obtained and documented?
           ❑ Yes ❑ No
         - iv. How many doses are being requested for a 3 month duration? _____ doses per 3 months
       - ❑ **YES:** ***Please answer the following questions below:***
         - i. What type of SMA does the patient have?
           - ❑ Type I (infantile onset or Werdnig-Hoffman disease)

1. Has the patient had an improvement from baseline in their motor milestone score? ❑ Yes ❑ No

❑ Type II (intermediate SMA)

2. Has the patient had an improvement from baseline in their motor milestone score of 2 points?
   ❑ Yes ❑ No

❑ Type III (mild SMA or Kugleber-Welander disease)

3. Has the patient had an improvement from baseline in their motor milestone score of 2 points?
   ❑ Yes ❑ No

❑ Type IV (adult onset SMA)

ii. How many doses are being requested for a 12 month duration? _____ doses per 12 months

❑ Other diagnosis *(please specify):* _____

2. Does the patient have a platelet count of 50,000 cells per microliter or greater? ❑ Yes ❑ No
3. Does the prescriber agree to do a platelet count and coagulation test before each dose? ❑ Yes ❑ No
4. Does the prescriber agree to do quantitative spot urine testing before each dose? ❑ 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**