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	**Zilretta**	**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:

NOTE: Form must be completed in its entirety for processing

1. What is the patient's diagnosis?

❑ Osteoarthritis (OA, DJD) of the knee(s)

a. Which knee is being treated? ❑ Left knee ❑ Right knee ❑ Both knees

b. Has the member received a previous Zilretta injection in the requested area? ❑Yes ❑No

❑ Other diagnosis ***(please specify)***: _____

2. Has the patient failed to achieve an adequate response to 2 or more of the following conservative non-pharmacologic therapy below?

Cardiovascular (aerobic) activity, such as: walking, biking, stationary bike, aquatic exercise ❑Yes ❑No		
Occupational therapy ❑Yes ❑No	Resistance exercise ❑Yes ❑No	Participation in self-management programs ❑Yes ❑No
Physical therapy ❑Yes ❑No	Walking aids ❑Yes ❑No	Wearing of medially directed patellar taping ❑Yes ❑No
Thermal agents ❑Yes ❑No	Weight reduction ❑Yes ❑No	Wearing of wedged insoles ❑Yes ❑No
Other failed therapy ***(please specify)***: _____		

3. Has the patient had an inadequate response, intolerance or contraindication to 2 or more of the following: acetaminophen, oral NSAIDs, or topical NSAIDs? ❑Yes ❑No*
   If NO, please specify other treatment not listed: _____

4. Has the patient had an inadequate response, intolerance or contraindication to short acting intra-articular steroid injections in which efficacy lasted less than 8 weeks? ❑Yes ❑No

5. Does the patient have radiologic confirmation of Kellgren-Lawrence Scale score of grade 2 or greater? ❑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**