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	{Auth.Member.MemberNameFirst} {Auth.Member.MemberNameLast}	**Name**	{Auth.ProviderBilling.Name.Legal}
ID Number	{Auth.Member.MemberID}	**Specialty**	
D.O.B.	{Auth.Member.MemberBirthDate} ❑Male ❑Female	**Address**	
Diagnosis		**City /State/Zip**	
Drug Name	**Tysabri**	**Phone:** {Auth.OfficeContactPhoneNumber} **Fax:** {Auth.OfficeContactFaxNumber}	
Dose and Quantity		**NPI**	{Auth.ProviderBilling.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.**

Site of Care:

A. At what location will the member be receiving the requested medication?
- ❑ Physician's office, home infusion, non-hospital affiliated ambulatory infusion center.
- ❑ Outpatient hospital infusion center. Please provide the name of the infusion center and rationale why the patient must receive this medication in a hospital outpatient setting. _____
  _____
- ❑ Other. Please specify. _____

Criteria Questions:

1. Has the patient been on Tysabri continuously for the last **3 months**, excluding samples? ***Please select answer below:***
   - ❑ **YES** - this is a PA renewal for the **CONTINUATION** of therapy, please answer the questions on **continuation section.**
   - ❑ **NO** – this is **INITIATION** of therapy, please answer the questions below:

2. What is the patient's diagnosis?
   - ❑ Crohn's Disease (CD)
     a. Does the patient have moderately to severely active Crohn's disease? ❑Yes ❑No
     b. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to conventional Crohn's disease therapy? ❑Yes* ❑No
        If YES, does the patient have an intolerance or contraindication or have they had an inadequate treatment response to TNF inhibitors? ❑Yes ❑No
     c. Will Tysabri be used in combination with immunosuppressants or TNF inhibitors? ❑Yes* ❑No
        If YES, please specify the medication: _____
   - ❑ Multiple Sclerosis (MS)
     a. Does the patient have any of the following diagnoses listed below:
        - ❑ Active Secondary Progressive Multiple Sclerosis (SPMS)
        - ❑ Relapsing-Remitting Multiple Sclerosis (RRMS)
        - ❑ Clinically Isolated Syndrome (CIS)
        - ❑ Relapsing Multiple Sclerosis (MS)
        - ❑ None of the above

     b. Does the patient have advanced, progressive, or severe disease? ❑Yes ❑No*
        If NO, does the patient have an intolerance or contraindication or have they had an inadequate treatment response to another MS therapy? ❑Yes ❑No
     c. Will the Tysabri be used as monotherapy? ❑Yes ❑No
     d. Will Tysabri be used in combination with other MS disease modifying agents? ❑Yes* ❑No
        If YES, please specify the medication: _____
   - ❑ Other diagnosis ***(please specify):*** _____

3. Does the patient currently have or have had progressive multifocal leukoencephalopathy (PML)? ❑Yes ❑No

4. Will the patient be monitored for any new signs or symptoms that may be suggestive of PML? ❑Yes* ❑No
   If YES, will Tysabri be withheld at the first sign or symptom suggestive of PML? ❑Yes ❑No

5. Does the patient have significantly compromised immune system function? ❑Yes ❑No

6. Will the patient be given live vaccines while on Tysabri? ❑Yes ❑No

7. Is the patient enrolled in and meet all the conditions of the TOUCH Prescribing Program? ❑Yes ❑No

CONTINUATION OF THERAPY (PA RENEWAL)

Tysabri (natalizumab)

NOTE: Form must be completed in its **entirety** for processing

1. Has the patient been on Tysabri continuously for the last **3 months**, excluding samples? ***Please select answer below:***
   ❑ **NO** – this is **INITIATION** of therapy, please answer the questions on **initiation section.**
   ❑ **YES** - this is a PA renewal for the **CONTINUATION** of therapy, please answer the questions below:

2. What is the patient's diagnosis?
   ❑ Crohn's Disease (CD)
      a. Has the patient experienced therapeutic benefit after 12 weeks of induction therapy? ❑Yes ❑No
      b. Will Tysabri be used in combination with immunosuppressants or TNF inhibitors? ❑Yes* ❑No
         If YES, please specify the medication: _____
   ❑ Multiple Sclerosis (MS)
      a. Does the patient have any of the following diagnoses listed below:
         ❑ Active Secondary Progressive Multiple Sclerosis (SPMS)
         ❑ Relapsing-Remitting Multiple Sclerosis (RRMS)
         ❑ Clinically Isolated Syndrome (CIS)
         ❑ Relapsing Multiple Sclerosis (MS)
         ❑ None of the above
      b. Will Tysabri be used as monotherapy? ❑Yes ❑No
      c. Will Tysabri be used in combination with other MS disease modifying agents? ❑Yes* ❑No
         If YES, please specify the medication: _____
   ❑ Other diagnosis ***(please specify):*** _____

3. Does the patient have progressive multifocal leukoencephalopathy (PML)? ❑Yes ❑No
4. Does the patient have evidence of jaundice or liver injury? ❑Yes ❑No
5. Has the patient developed an opportunistic infection? ❑Yes ❑No
6. Has the patient developed herpes infections? ❑Yes ❑No
7. Will the patient be given live vaccines while on Tysabri? ❑Yes ❑No
8. Is the patient enrolled in and meet all the conditions of the TOUCH Prescribing Program? ❑Yes ❑No
9. Is the patient receiving concurrent therapy with systemic corticosteroids? ❑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**