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.	☐ Male ☐ Female	**Address**
Diagnosis		**City /State/Zip**
Drug Name	**PROLIA**	**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.**

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. ____

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Criteria Questions:

1. What is the patient's diagnosis?
   ❑ Breast cancer
   a. Is the patient a female patient with breast cancer? ❑ Yes ❑ No
   b. Is the patient currently receiving *aromatase-inhibitor therapy? ❑ Yes ❑ No
   Aromatase-inhibitor therapy examples: anastrozole (Arimidex), letrozole (Femara), and exemestane (Aromasin)

   ❑ Prostate cancer
   a. Is the patient a male patient with non-metastatic prostate cancer? ❑ Yes ❑ No
   b. Is the patient currently receiving *androgen deprivation therapy? ❑ Yes ❑ No
   Androgen deprivation therapy examples: bicalutamide (Casodex), flutamide (Eulexin), nilutamide (Nilandron), leuprolide (Lupron Eligard), and goserelin (Zoladex)

   ❑ Osteoporosis

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

2. Will Prolia be used in combination with another prior authorization medication for osteoporosis? ❑ Yes* ❑ No
   ***If YES**, please select the medication below:
   ❑ Evenity (romosuzumab-aggg) ❑ Forteo (teriparatide) ❑ Teriparatide (teriparatide) ❑ Tymlos (abaloparatide) ❑ Other medication ***(please specify)***: ____

3. Has the patient been administered a Prolia injection in the last **6 months**, excluding samples? ❑ Yes ❑ No*
   ***If NO**, please answer the following questions:
   a. Does the patient have pre-existing hypocalcemia? ❑ Yes** ❑ No
   ****If YES,** will the pre-existing hypocalcemia be corrected prior to initiating therapy? ❑ Yes ❑ No
   b. Is the patient at high risk for bone fracture(s)? ❑ Yes ❑ No
   c. Does the patient have an intolerance, contraindication or have they had an inadequate treatment response to *bisphosphonate therapy? ❑ Yes ❑ No
   **** Bisphosphonates examples include alendronate (Fosamax), ibandronate (Boniva), risedronate (Actonel/Atelvia), and zoledronic acid (Reclast).***

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**

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