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	**Signifor LAR**	**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. Has the patient been on Signifor LAR continuously for the last **6 months**, excluding samples?
   Please select answer below:

   ❑ **NO** – this is **INITIATION** of therapy, please answer the following questions:

   a. What is the patient's diagnosis?

      ❑ Acromegaly

      i. Has the patient had surgery that was not curative? ❑Yes ❑No*
      If NO, is the patient a candidate for surgery? ❑Yes ❑No

      ii. Has the patient had an inadequate response, intolerance, or contraindication to octreotide or lanreotide? ❑Yes ❑No

      ❑ Cushing's disease

      i. Is the patient a candidate for surgery? ❑Yes ❑No

      ii. Has the patient received pituitary surgery for their Cushing's disease? ❑Yes* ❑No
      If YES, was the pituitary surgery curative? ❑Yes ❑No

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

   ❑ **YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:

   a. What is the patient's diagnosis?

      ❑ Acromegaly

      ❑ Cushing's disease

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

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**