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	**Cinqair**	**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. _____

Criteria Questions:

1. What is the patient's diagnosis?
❑ Asthma with an eosinophilic phenotype
❑ Other diagnosis ***(please specify):*** _____
2. Is Cinqair being used to treat other eosinophilic conditions? ❑ Yes ❑ No
3. Is Cinqair being used for the relief of acute bronchospasm or status asthmaticus? ❑ Yes ❑ No
4. Is Cinqair being used in combination with another monoclonal antibody for the treatment of asthma? ❑ Yes* ❑ No
If YES, specify the medication: _____

5. Has the patient been on Cinqair continuously for the last **4 months**, excluding samples? ***Please select answer below:***

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

a. Is the patient's diagnosis severe? ❑ Yes ❑ No

b. Has the patient had inadequate control of asthma symptoms after a minimum of three months of compliant use defined as greater than or equal to 50% adherence with a corticosteroid inhaler in combination with a long acting $beta_2$-agonist within the past six months? ❑ Yes ❑ No*****
****If NO***, has the patient had inadequate control of asthma symptoms after a minimum of three months of compliant use defined as greater than or equal to 50% adherence with a corticosteroid inhaler in combination with a long acting muscarinic antagonist within the past six months? ❑ Yes ❑ No

c. Does the patient have an eosinophil count greater than or equal to 150 cells/mcL in the past 90 days? ❑ Yes ❑ No *****
****If NO***, does the patient have an eosinophil count greater than or equal to 300 cells/mcL in the past 12 months?

d. ❑ Yes ❑ No Is Cinqair being administered by a healthcare professional with appropriate medical support to manage anaphylaxis and will the patient be monitored for an appropriate period of time after infusion? ❑ Yes ❑ No

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

a. Has the patient had a documented decrease in exacerbations and improvement in symptoms? ❑ Yes ❑ No

b. Has the patient decreased utilization of rescue medications? ❑ Yes ❑ No

c. Has the patient been compliant on Cinqair therapy? ❑ 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**