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	**Xolair**	**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 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:

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

a. Will this medication be used in combination with another monoclonal antibody for the treatment of asthma or COPD? ❑Yes***** ❑No

****If YES***, please specify the medication: _____

b. Is this request for **INITIATION** or **CONTINUATION** of therapy? ***Please select answer below:***

❑ **INITIATION** of therapy, please answer the following questions:

i. Does the patient have moderate to severe asthma? ❑Yes ❑No

ii. What is the patient's baseline (pre-treatment) serum IgE? _____ IU/mL ❑Test not completed

iii. Has patient had inadequate control of asthma symptoms after a minimum of 3 months of compliant use defined as greater than or equal to 50% adherence with a corticosteroid inhaler in combination with a long acting beta2-agonist within the past 6 months? ❑Yes ❑No*****

****If NO***, has patient had inadequate control of asthma symptoms after a minimum of 3 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 6 months? ❑Yes ❑No

iv. Does the patient have a positive skin prick test response **OR** a positive RAST response to at least one common allergen? ❑Yes ❑No

❑ **CONTINUATION (PA renewal)** of therapy, please answer the following questions:

i. Has the patient had a break or interruption in treatment? ❑Yes***** ❑No

****If YES***, please answer the following questions:

1) Has the interruption in treatment lasted 1 year or longer? ❑Yes ❑No

2) Has the patient's serum IgE level been re-tested since the interruption in treatment? ❑Yes***** ❑No

****If YES***, what is the patient's re-tested serum IgE? _____ IU/mL

ii. Has the patient had decreased exacerbations or an improvement in symptoms? ❑Yes ❑No

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

❑ Chronic rhinosinusitis with nasal polyps (CRSwNP)

a. Will this medication be used in combination with another monoclonal antibody for the treatment of CRSwNP? ❑Yes* ❑No

****If YES***, please specify the medication: _____

b. Will this medication be used as add-on maintenance treatment? ❑Yes ❑No

c. Is this request for **INITIATION** or **CONTINUATION** of therapy? ***Please select answer below:***

❑ **INITIATION** of therapy, please answer the following questions:

i. What is the patient's baseline (pre-treatment) serum IgE? _____ IU/mL ❑Test not completed

ii. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a 3-month trial of **TWO** nasal corticosteroid sprays (i.e., mometasone, fluticasone, budesonide, or triamcinolone)? ❑Yes ❑No

❑ **CONTINUATION (PA renewal)** of therapy, please answer the following questions:

i. Has the patient had improvements in sino nasal symptoms? ❑Yes ❑No

ii. Has the patient had a break or interruption in treatment? ❑Yes***** ❑No

****If YES***, please answer the following questions:

1) Has the interruption in treatment lasted 1 year or longer? ❑Yes ❑No

2) Has the patient's serum IgE level been re-tested since the interruption in treatment? ❑Yes***** ❑No

****If YES***, what is the patient's re-tested serum IgE? _____ IU/mL

❑ Chronic spontaneous urticaria (CSU)

a. Has the patient been on this medication continuously for the last **6 months** excluding samples? ***Please select answer below:***

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

i. Does the patient have a baseline *****urticarial activity score (UAS)? ❑Yes***** ❑No

****If YES***, please specify score: _____

****Urticarial Activity Score:*** **https://www.mdcalc.com/urticaria-activity-score-uas**

ii. Has the patient remained symptomatic after at least **TWO** previous trials of H1-antihistamines? ❑Yes ❑No

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

i. Has the patient's urticaria activity score (UAS) decreased, such as improvement in pruritic wheals, hives, and itching? ❑Yes***** ❑No

****If YES***, please specify score: _____

****Urticarial Activity Score:*** **https://www.mdcalc.com/urticaria-activity-score-uas**

❑ IgE-mediated food allergy

a. Will this medication be used for the reduction of allergic reactions that may occur with accidental exposure to one or more foods? ❑Yes ❑No

b. Will this medication be used in conjunction with food allergen avoidance? ❑Yes ❑No

c. Will this medication be used for emergency treatment of allergic reactions, including anaphylaxis? ❑Yes ❑No

d. Is this request for **INITIATION** or **CONTINUATION** of therapy? ***Please select answer below:***

❑ **INITIATION** of therapy, please answer the following questions:

i. What is the patient's baseline (pre-treatment) serum lgE? _____ IU/mL ❑Test not completed

ii. Is the patient allergic to peanut **AND** at least two other foods (e.g., milk, egg, wheat, cashew, hazelnut, or walnut) with positive food specific IgE greater than or equal to 6 kUA/L for each? ❑Yes ❑No

❑ **CONTINUATION (PA renewal)** of therapy, please answer the following question:

i. Has the patient had a break or interruption in treatment? ❑Yes***** ❑No

****If YES***, please answer the following questions:

1) Has the interruption in treatment lasted 1 year or longer? ❑Yes ❑No

2) Has the patient's serum IgE level been re-tested since the interruption in treatment? ❑Yes***** ❑No

****If YES***, what is the patient's re-tested serum IgE? _____ IU/mL

❑ 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**