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	**Cinryze**	**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.**

Criteria Questions:

1. What is the patient's diagnosis?
   ❑ Hereditary Angioedema (HAE) ❑ Other diagnosis ***(please specify)***: _____
2. Is Cinryze being used to treat acute attacks or for the routine prevention of angioedema attacks? ❑ Acute attacks ❑ Routine prevention
3. Will the patient also be using another agent for the prevention of hereditary angioedema attacks (e.g., Haegarda, Orladeyo, Takhzyro)?
   ❑ Yes***** ❑ No
   ****If YES***, specify the medication: _____
4. Has the patient been on Cinryze continuously for the last **6 months**, excluding samples? ***Please select answer below:***
   ❑ **NO –** this is **INITIATION** of therapy, please answer the following questions:
   a. Does the patient have a normal C1 inhibitor as confirmed by laboratory testing? ***Select answer below:***
      ❑ **Yes**: Please answer the following questions:
      i. Does the patient have a F12, angiopoietin-1, plasminogen, or kininogen-1 (KNG1) gene mutation as confirmed by genetic testing? ❑Yes ❑No
      ii. Does the patient have a documented family history of angioedema? ❑ Yes***** ❑ No
      ****If YES***, is the angioedema refractory to a trial of high-dose antihistamine such as cetirizine for at least one month?
      ❑ Yes ❑ No
      ❑ **No**: Please answer the following questions:
      i. Does the patient have a C1 inhibitor deficiency for dysfunction as confirmed by laboratory testing?
      ❑ Yes ❑ No
      ii. Is the patient's C4 level below the lower limit of normal as defined by the laboratory performing the test?
      ❑ Yes ❑ No
      iii. Does the patient have a normal C1-INH antigenic level as defined by the laboratory performing the test?
      ❑ **Yes**: Does the patient have a C1-INH functional level less than 50% or a C1-INH functional level below the lower limit of normal as defined by the laboratory performing the test? ❑ Yes ❑ No
      ❑ **No**: Is the patient's C1 inhibitor (C1-INH) antigenic level below the lower limit of normal as defined by the laboratory performing the test? ❑ Yes ❑ No
   b. Has the patient had an inadequate treatment response or have an intolerance to a short-term course (5 days or less) of an androgen such as danazol? ❑ Yes ❑ No
   c. Does the patient have one of the following that would be a contraindication to an androgen such as danazol? ***Answer below:***

      ❑Active thrombosis or history of thromboembolic disease ❑Androgen-dependent tumor ❑Breast feeding
      ❑Markedly impaired hepatic, renal or cardiac function ❑Porphyria ❑Prepubertal child
      ❑Pregnancy (member is currently pregnant or may become pregnant) ❑Undiagnosed abnormal genital bleeding
      ❑Other reason ***(please specify)***: _____
      ❑None of the above

   ❑ **YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:
   a. Has the patient experienced a significant reduction in frequency of hereditary angioedema attacks since starting treatment?
      ❑ 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**