Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

Medical benefit drug policies are a source for BCBSM and BCN medical policy information only. These documents are not to be used to determine benefits or reimbursement. Please reference the appropriate certificate or contract for benefit information. This policy may be updated and therefore subject to change.

P&T Date: 06/11/2026

## Colony Stimulating Factors (CSFs)

| Drug | HCPCS |
|---|---|
| **Armlupeg**™ (pegfilgrastim-unne) | Q5169 |
| **Ennumo**™ (pegfilgrastim-pccg) | J3590 |
| **Filkri**® (filgrastim-laha) | J3590 |
| **Fulphila**™ (pegfilgrastim-jmbd) | Q5108 |
| **Fylnetra**® (pegfilgrastim-pbbk) | Q5130 |
| **Granix**® (tbo-filgrastim) | J1447 |
| **Leukine**® (sargramostim) | J2820 |
| **Neulasta**® (pegfilgrastim) | J2506 |
| **Neulasta On-Pro**® (pegfilgrastim) | J2506 |
| **Neupogen**® (filgrastim) | J1442 |
| **Nivestym**™ (filgrastim-aafi) | Q5110 |
| **Nypozi**™ (filgrastim-txid) | Q5148 |
| **Nyvepria**™ (pegfilgrastim-apgf) | Q5122 |
| **Releuko**™ (filgrastim-ayow) | Q5125 |
| **Rolvedon**™ (eflapegrastim-xnst) | J1449 |
| **Ryzneuta**® (efbemalenograstim alfa-vuxw) | J9361 |
| **Stimufend**® (pegfilgrastim-fpgk) | Q5127 |
| **Udenyca**™ (pegfilgrastim-cbqv) | Q5111 |
| **Udenyca Onbody**™ (pegfilgrastim-cbqv) | Q5111 |
| **Zarxio**® (filgrastim-sndz) | Q5101 |
| **Ziextenzo**™ (pegfilgrastim-bmez) | Q5120 |

**Policy:**

*Requests must be supported by submission of chart notes and patient specific documentation.*

A. Coverage of the requested drug is provided when all the following are met:
   a. Primary prophylaxis of chemotherapy-induced febrile neutropenia is considered clinically appropriate when ALL of the following are met:

i. The individual has a non-myeloid malignancy
ii. The individual falls into one of the following risk categories for febrile neutropenia:
    1. High risk of febrile neutropenia (≥ 20%) based on chemotherapy regimen; OR
    2. Intermediate risk of febrile neutropenia (≥ 10% but < 20%) based on chemotherapy regimen, and at least ONE of the following significant risk factors:
        a) Age > 65
        b) Poor performance status (ECOG 3 or 4, but chemotherapy still indicated)
        c) Preexisting neutropenia, for example resulting from bone marrow damage or tumor infiltration (ANC < 1500 $mm^3$)
        d) Previous febrile neutropenia episode from a prior treatment regimen
        e) Liver dysfunction, with bilirubin ≥ 1.0 or liver enzymes ≥ 2x upper limit of normal
        f) Presence of open wounds or active infections, when chemotherapy cannot be delayed to accommodate recovery
        g) Renal dysfunction with creatinine clearance of less than 50 mL/min
        h) Poor nutritional status (baseline albumin less ≤ 3.5 g/dL or BMI less than 20)
        i) HIV infection
        j) Advanced cancer (i.e. metastatic or stage IV, unresectable disease).
        k) Multiple (5 or more) chronic conditions or at least two serious comorbidities
    3. Low risk of febrile neutropenia (>10%) based on chemotherapy regimen, and
        a) Dose reduction is not clinically appropriate
        b) Member has at least TWO of the following significant risk factors:
            1) Age > 65
            2) Poor performance status (ECOG 3 or 4, but chemotherapy still indicated)
            3) Preexisting neutropenia, for example resulting from bone marrow damage or tumor infiltration (ANC < 1,500 $mm^3$)
            4) Previous febrile neutropenia episode from a prior treatment regimen
            5) Liver dysfunction, with bilirubin ≥ 1.0 or liver enzymes ≥ 2x upper limit of normal
            6) Presence of open wounds or active infections, when chemotherapy cannot be delayed to accommodate recovery
            7) Renal dysfunction with creatinine clearance of less than 50 mL/min
            8) Poor nutritional status (baseline albumin less ≤ 3.5 g/dL or BMI less than 20)
            9) HIV infection
            10) Advanced cancer (i.e. metastatic or stage IV, unresectable disease).
            11) Multiple (5 or more) chronic conditions or at least two serious comorbidities

b. Secondary Prophylaxis of febrile neutropenia is considered clinically appropriate when there has been a previous neutropenic complication (in the absence of primary prophylaxis), and a change to the regimen (including dose reduction, schedule change, or change in therapy) would be expected to compromise patient outcome, particularly in the setting of curative intent.
c. Adjunctive treatment of febrile neutropenia is considered clinically appropriate when any of the following risk factors are present:
    i. Age > 65
    ii. Neutrophil recovery is expected to be delayed (greater than 10 days)
    iii. Neutropenia is profound (less than 0.1 x $10^9$)
    iv. Active pneumonia
    v. Sepsis syndrome (hypotension and/or multi-organ damage/dysfunction noted)
    vi. Invasive fungal or opportunistic infection
    vii. Onset of fever during inpatient stay

d. The following indications by growth factor type are also considered clinically appropriate when the requirements below are met:
    i. Filgrastim and filgrastim biosimilars
        1. Acute lymphocytic leukemia (ALL)
            a) After start of induction or first post-remission chemotherapy course; OR
            b) As an alternate or adjunct to donor leukocyte infusions (DLI) for relapsed disease after transplant
        2. Acute myeloid leukemia (AML)
            a) After induction, reinduction, or consolidation; OR
            b) As an alternate or adjunct to donor leukocyte infusions (DLI) for relapsed disease after transplant
        3. Aplastic anemia, moderate or severe
        4. To treat severe neutropenia in hairy cell leukemia
        5. Hematopoietic stem cell transplant
            a) To promote bone marrow myeloid recovery; OR
            b) To treat delayed or failed engraftment; OR
            c) To mobilize stem cells for collection by pheresis
        6. Myelodysplastic syndrome (MDS)
            a) To treat recurrent infection; OR
            b) To treat neutrophil count < 500 $mm^3$
        7. Radiation exposure
            a) Following radiation therapy in the absence of chemotherapy, if prolonged delays are expected; OR
            b) After accidental or intentional body irradiation of doses greater than 2 Gy (hematopoietic syndrome of acute radiation syndrome)
        8. Support for dose dense or dose intensive chemotherapy in any of the following scenarios:
            a) Adjuvant treatment of high-risk breast cancer with combination therapy that includes anthracycline (doxorubicin or epirubicin)/cyclophosphamide followed by paclitaxel; OR
            b) High-dose intensity methotrexate, vinblastine, doxorubicin, and cisplatin (HD-M-VAC) in urothelial cancer; OR
            c) Chemotherapy intensification for newly diagnosed, localized Ewing sarcoma
    ii. Peg-filgrastim and peg-filgrastim biosimilars
        1. Acute lymphocytic leukemia (ALL) after the start of induction of first post-remission chemotherapy course
        2. Hematopoietic stem cell transplant
            a) To promote bone marrow myeloid recovery; OR
            b) To treat delayed or failed engraftment
        3. Myelodysplastic syndrome (MDS)
            a) To treat recurrent infection; OR
            b) To treat neutrophil count < 500 $mm^3$
        4. After accidental or intentional body irradiation of doses greater than 2 Gy (hematopoietic syndrome of acute radiation syndrome)
        5. Support for dose dense chemotherapy in any of the following scenarios:
            a) Adjuvant treatment of high-risk breast cancer with combination therapy that includes anthracycline (doxorubicin or epirubicin)/cyclophosphamide followed by paclitaxel; OR
            b) High-dose intensity methotrexate, vinblastine, doxorubicin, and cisplatin (HD-M-VAC) in urothelial cancer; OR
            c) Chemotherapy intensification for newly diagnosed, localized Ewing sarcoma
    iii. Sargramostim

1. Acute lymphocytic leukemia (ALL) after the start of induction or first post-remission chemotherapy course
2. Acute myeloid leukemia (AML) after induction, reinduction, for individuals over 55 years of age
3. Hematopoietic stem cell transplant
    a) To promote bone marrow myeloid recovery; OR
    b) To treat delayed or failed engraftment; OR
    c) To mobilize stem cells for collection by pheresis
4. Myelodysplastic syndrome (MDS)
    a) To treat recurrent infection; OR
    b) To treat neutrophil count < 500 $mm^3$
5. Radiation exposure
    a) After radiation therapy in the absence of chemotherapy, if prolonged delays are expected; OR
    b) After accidental or intentional body irradiation of doses greater than 2 Gy (hematopoietic syndrome of acute radiation syndrome)
6. Support for dose dense chemotherapy in any of the following scenarios:
    a) Adjuvant treatment of high-risk breast cancer with combination therapy that includes anthracycline (doxorubicin or epirubicin)/cyclophosphamide followed by paclitaxel; OR
    b) High-dose intensity methotrexate, vinblastine, doxorubicin, and cisplatin (HD-M-VAC) in urothelial cancer; OR
    c) Chemotherapy intensification for newly diagnosed, localized Ewing sarcoma
7. In combination with naxitamab for pediatric patients one year of age and older and adult patients with relapsed or refractory high-risk neuroblastoma in the bone or bone marrow demonstrating a partial response, minor response, or stable disease to prior therapy
8. In combination with dinutuximab, interleukin-2, and 13-cis-retinoic acid for the pediatric patients with high risk neuroblastoma who achieve at least a partial response to prior first line multiagent, multimodal therapy

iv. Tbo-filgrastim for use in hematopoietic stem cell transplant in any of the following scenarios:
1. To promote bone marrow myeloid recovery; OR
2. To treat delayed or failed engraftment; OR
3. To mobilize stem cells for collection by pheresis

e. Coverage will be provided for biosimilar products for FDA labeled indications of the innovator product when criteria are met
f. Trial and failure, contraindication, OR intolerance to the preferred drugs as listed in BCBSM/BCN's utilization management medical drug list and/or BCBSM/BCN's prior authorization and step therapy documents.

B. Quantity Limitations and Authorization Period
a. Quantity Limits: Align with FDA approved dosing
b. Initial Authorization Period: Aligns with FDA recommended or guideline supported treatment duration and provided for at least 60 days up to 6 months at a time

C. Renewal Criteria:
a. Authorization may be reviewed at least annually to confirm that current criteria are met and that the medication is effective as demonstrated by a decrease in the interruption of chemotherapy cycles and reduced incidence of febrile neutropenia
b. Renewal Authorization Period: Aligns with FDA recommended or guideline supported treatment duration and provided for at least 60 days up to 6 months at a time

***Note: Coverage and approval duration may differ for Medicare Part B members based on any applicable criteria outlined in Local Coverage Determinations (LCD) or National Coverage Determinations (NCD) as determined by Center for Medicare and Medicaid Services (CMS). See the CMS website at http://www.cms.hhs.gov/. Determination of coverage of Part B drugs is based on medically accepted indications which have supported citations included or approved for inclusion determined by CMS approved compendia.

**Background Information:**

- There are different types of colony stimulating factors (CSFs). Filgrastim-products, pegfilgrastim products and Leukine is the only sargramostim product. Filgrastim and pegfilgrastim products are human granulocyte colony-stimulating factors (G-CSFs). Leukine is a human granulocyte-macrophage CSF (GM-CSF).

- Filgrastim products:

    - Granix is FDA approved to reduce the duration of severe neutropenia in patients with non-myeloid malignancies receiving myelosuppressive anti-cancer medications associated with a clinically-significant incidence of febrile neutropenia. It is not technically considered a biosimilar because it was filed as a Biologics License Application since a biosimilars approval pathway had not been established at the time of FDA submission.

    - Neupogen is approved to:

        - Decrease the incidence of infection, as manifested by febrile neutropenia, in patients with non-myeloid malignancies receiving myelosuppressive anti-cancer drugs associated with a significant incidence of severe neutropenia and fever.

        - Reduce the time to neutrophil recovery and the duration of fever following induction or consolidation chemotherapy treatment of adults with AML.

        - Reduce the duration of neutropenia and neutropenia-related clinical sequelae (e.g., febrile neutropenia) in patients with non-myeloid malignancies undergoing myeloablative chemotherapy followed by BMT.

        - Mobilization of autologous hematopoietic progenitor cells into the peripheral blood for collection by leukapheresis.

        - Chronic administration to reduce the incidence and duration of sequelae of neutropenia in symptomatic patients with congenital neutropenia, cyclic neutropenia, or idiopathic neutropenia.

        - Increase survival in patients acutely exposed to myelosuppressive doses of radiation (hematopoietic syndrome of acute radiation syndrome).

    - All of Neupogen's biosimilars are approved for the same indications as Neupogen with the exception of use to increase survival in patients acutely exposed to myelosuppressive doses of radiation (hematopoietic syndrome of acute radiation syndrome) which Nivestym is not indicated for.

- Pegfilgrastim products:

    - Neulasta is approved to:

        - Decrease the incidence of infection, as manifested by febrile neutropenia, in patients with non-myeloid malignancies receiving myelosuppressive anti-cancer drugs associated with a clinically-significant incidence of febrile neutropenia. Limitation of Use: This agent is not indicated for mobilization of peripheral blood progenitor cells for HSCT.

        - Increase survival in patients acutely exposed to myelosuppressive doses of radiation (hematopoietic subsyndrome of acute radiation syndrome).

    - All of Neulasta' s biosimilars are approved for the same indications as Neulasta with the exception of increasing survival in patients acutely exposed to myelosuppressive doses of radiation. Armlupeg, Ennumo, Stimufend, Udenyca, and Ziextenzo are approved for this indication.

- Sargramostim is approved:

    - To shorten time to neutrophil recovery and to reduce the incidence of severe, life-threatening or fatal infections following induction chemotherapy in adult patients ≥ 55 years of age with AML.

    - In adult patients with cancer undergoing autologous hematopoietic stem cell transplantation for the mobilization of hematopoietic progenitor cells into peripheral blood for collection by leukapheresis.

    - To accelerate myeloid reconstitution following autologous peripheral blood progenitor cell or bone marrow transplantation in adult and pediatric patients ≥ 2 years of age with non-Hodgkin's lymphoma, lymphoblastic leukemia, and Hodgkin's lymphoma.

    - For acceleration of myeloid reconstitution in adult and pediatric patients ≥ 2 years of age undergoing allogeneic bone marrow transplantation from HLA-matched related donors.

    - Treatment of adult and pediatric patients ≥ 2 years of age who have undergone allogeneic or autologous BMT in whom neutrophil recovery is delayed or failed.

    - To increase survival in adult and pediatric patients from birth to 17 years of age acutely exposed to myelosuppressive doses of radiation (hematopoietic syndrome of acute radiation syndrome).

- Eflapegrastim and efbemalenograstim alfa-vuxw are approved:

    - To decrease the incidence of infection, as manifested by febrile neutropenia, in adult patients with nonmyeloid malignancies receiving myelosuppressive anti-cancer drugs associated with clinically significant incidence of febrile neutropenia

- CSF products have an established role in the management of patients with non-myeloid malignancies who are receiving myelosuppressive anti-cancer agents, as well as for several other uses. Many studies have shown that the prophylactic use of these products reduces the incidence, duration, and severity of febrile neutropenia, decrease the subsequent rates of infection and hospitalization, and improves the delivery of full-dose intensity chemotherapy on schedule in patients with various cancers.

- The National Comprehensive Cancer Network (NCCN) guidelines for various cancer and myeloid growth factors provides recommendations on the use of these agents. The criteria reflects these recommendations along with expert opinion.

- Regarding biosimilars, the NCCN guidelines state an FDA approved biosimilar is an appropriate substitution for its reference products.

**References:**


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| Policy History | | |
|---|---|---|
| # | Date | Change Description |
| 4.4 | Effective Date: 08/12/2026 | UM medical management system update for BCBS, BCN, MAPPO, and BCNA for Armlupeg |
| 4.3 | Effective Date: 06/11/2026 | Updated to include Ennumo |
| 4.2 | Effective Date: 02/12/2026 | Updated to include Armlupeg and Filkri |
| 4.1 | Effective Date: 08/07/2025 | Annual review performed - no changes to criteria |
| 4.0 | Effective Date: 06/01/2025 | UM medical management system update for MAPPO and BCNA for Nypozi |
| 3.9 | Effective Date: 08/08/2024 | Updated to include Nypozi and add the statement that biosimilars will be approved for all indications of the innovator product when criteria is met |
| 3.8 | Effective Date: 07/18/2024 | UM medical management system update for BCBS and BCN for Nypozi |
| 3.7 | Effective Date: 04/11/2024 | Updated to remove the chemotherapy intent requirement and include criteria for use in low risk febrile neutropenia |
| 3.6 | Effective Date: 04/01/2024 | UM medical management system update for MAPPO and BCNA for Ryzneuta and Udenyca Onbody |
| 3.5 | Effective Date: 03/05/2024 | UM medical management system update for BCBS and BCN for Udenyca Onbody |
| 3.4 | Effective Date: 02/08/2024 | Updated to include Ryzneuta and Udenyca Onbody |
| 3.3 | Effective Date: 01/01/2024 | UM medical management system update for BCBS and BCN for Ryzneuta |
| 3.2 | Effective Date: 04/06/2023 | Updated the authorization period to aligns with FDA recommended or guideline supported treatment duration and provided for at least 60 days up to 6 months at a time |
| 3.1 | Effective Date: 03/13/2023 | UM medical management system update for Fylnetra and Rolvedon for BCBSM and BCN |
| 3.0 | Effective Date: 03/01/2023 | UM medical management system update for Stimufend and Rolvedon for BCNA and MAPPO |
| 2.9 | Effective Date: 02/02/2023 | UM medical management system update for Stimufend for BCBSM and BCN |
| 2.8 | Effective Date: 12/19/2022 | UM medical management system update for Fylnetra for BCNA and MAPPO |
| 2.7 | Effective Date: 12/01/2022 | Updated to include Rolvedon |
| 2.6 | Effective Date: 11/01/2022 | UM medical management system update for Releuko for BCBSM and BCN |
| 2.5 | Effective Date: 10/06/2022 | Updated to include Stimufend |
| 2.4 | Effective Date: 08/08/2022 | UM medical management system update for Releuko for BCNA and MAPPO |
| 2.3 | Effective Date: 08/04/2022 | Updated to include Fylnetra and add additional criteria for sargramostim supported by FDA labeling |
| 2.2 | Effective Date: 04/14/2022 | Updated to include Releuko |

<table>
<tr><td>2.1</td><td>Effective Date: 08/12/2021</td><td>Annual review performed, no changes to criteria</td></tr>
<tr><td>2.0</td><td>Effective Date: 10/01/2020</td><td>UM medical management system update for Neupogen and Granix for BCBSM</td></tr>
<tr><td>1.9</td><td>Effective Date: 08/13/2020</td><td>Added Nyvepria as a new drug</td></tr>
<tr><td>1.8</td><td>Effective Date: 12/05/2019</td><td>Added Ziextenzo as a new drug</td></tr>
<tr><td>1.7</td><td>Effective Date: 05/09/2019</td><td>Update per vendor recommendations</td></tr>
<tr><td>1.6</td><td>Effective Date: 12/06/2018</td><td>Added Udenyca</td></tr>
<tr><td>1.5</td><td>Effective Date: 08/09/2018</td><td>Adding change in indication for Leukine and added new approved biosimilars Fulphila and Nivestym</td></tr>
<tr><td>1.4</td><td>Effective Date: 11/09/2017</td><td>Annual review performed, no changes to criteria</td></tr>
<tr><td>1.3</td><td>Effective Date: 11/10/2016</td><td>Annual review performed, no changes to criteria</td></tr>
<tr><td>1.2</td><td>Effective Date: 05/05/2016</td><td>Updated due to new indication and dose for peg-filgrastim</td></tr>
<tr><td>1.1</td><td>Effective Date: 08/13/2015</td><td>Addition of Zarxio and added new indication to Neupogen</td></tr>
<tr><td>1.0</td><td>Effective Date: 05/08/2014</td><td>New policy<br><table><tr><th>Line of Business</th><th>PA Required in Medical Management System (Yes/No)</th></tr><tr><td>BCBS</td><td>No</td></tr><tr><td>BCN</td><td>No</td></tr><tr><td>MAPPO</td><td>No</td></tr><tr><td>BCNA</td><td>No</td></tr></table></td></tr>
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** The prescribing information for a drug is subject to change. To ensure you are reading the most current information it is advised that you reference the most updated prescribing information by visiting the drug or manufacturer website or [http://dailymed.nlm.nih.gov/dailymed/index.cfm](http://dailymed.nlm.nih.gov/dailymed/index.cfm).*

# Blue Cross Blue Shield
# Medication Authorization Request Form

Granix® (tbo-filgrastim) J1447, Neupogen® (filgrastim) J1442; Fulphila® (pegfilgrastim-jmdb) Q5108; Fylnetra® (pegfilgrastim-pbbk) Q5130; Neulasta® (pegfilgrastim) J2506; Nivestym®(filgrastim-aafi) Q5110; Nyvepri® (pegfilgrastim-apgf) Q5122; Releuko® (filgrastim-ayow) Q5125; Rolvedon® (eflapegrastim-xnsxt) J1449; Stimufend® (pegfilgrastim-fpgk) Q5127; Udenyca® (pegfilgrastim-cbqv) Q5111; Zarxio® (filgrastim-sndz) Q5101; Ziextenzo® (pegfilgrastim-bmez) Q5120, Udenyca® Onbody (pegfilgrastim-cbqv) Q5111, Ryzneuta (Efbemalenograstim alfa) J9361

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 Colony-Stimulating Factors. 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** | | **Phone/Fax: P**: ( ) - **F**: ( ) - |
| **Dose and Quantity** | | **NPI** |
| **Directions** | | **Contact Person** |
| **Date of Service(s)** | | **Contact Person Phone / Ext.** |

**STEP 1: DISEASE STATE INFORMATION**

1. Initial or Continuation request? ☐ Initial ☐ Continuation *Date patient started therapy:* _____

2. Please specify the location of administration (e.g. name of facility):
   _____

3. Please provide the NPI number for the place of administration: _____

4. **Initiation AND Continuation of therapy:**
   a. What is the patient's diagnosis? _____
      i. Is the requested drug being used to treat an FDA-approved indication?
      ☐ Yes ☐ No ☐ Unknown

   b. **For Granix, Releuko, or Neupogen:** Please select the preferred colony-stimulating factor(s) the patient has experienced an intolerance, contraindication, or adverse event for the requested indication. Please provide date and type of intolerance patient has had.
      ☐ Nivestym *Date*: _____ *Intolerance*: _____
      ☐ Zarxio *Date*: _____ *Intolerance*: _____
      ☐ Other; Please specify: _____

   c. **For Fulphila, Ziextenzo, Fylentra, Udenyca, Stimufend, Ryzneuta or Udenyca Onbody:** Please select the preferred colony-stimulating factor(s) the patient has experienced an intolerance, contraindication, or adverse event for the requested indication. Please provide date and type of intolerance patient has had.
      ☐ Udenyca *Date*: _____ *Intolerance*: _____
      ☐ Udenyca Onbody *Date*: _____ *Intolerance*: _____
      ☐ Nyvepria *Date*: _____ *Intolerance*: _____
      ☐ Fulphila *Date*: _____ *Intolerance*: _____
      ☐ Other; Please specify: _____

5. **Continuation of therapy -** *Please include rationale for continuation of therapy:*
   _____

*Please add any other supporting medical information necessary for our review*

**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<br>☐ Attached necessary chart notes | ☐ Important laboratory results |
| **Step 3:** Submit | **By Fax: BCBSM Specialty Pharmacy Mailbox**<br>**1-877-325-5979** | **By Mail: BCBSM Specialty Pharmacy Program**<br>**P.O. Box 312320, Detroit, MI 48231-2320** |



10/1/2020; 4/1/2021, 04/01/2023, 04/01/2024, 01/01/2025