Blue Cross Blue Shield Blue Care Network of Michigan

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

Medicare Plus Blue℠ and BCN Advantage℠

Medication Authorization Request Form (for any medication)

The most efficient way to request authorization is to use the Medical and Pharmacy Drug PA Portal. To access that portal, log in to availity.com*, click *Payer Spaces*, click the BCBSM and BCN logo and then click the *Medical and Pharmacy Benefit Drug Prior Auth* tile.

As an alternative, you can use this form to request authorization for any medical benefit drug that requires authorization for Medicare Plus Blue or BCN Advantage members. Please complete this form and submit via fax to 1-866-392-6465. If you have any questions regarding this process, please contact the Pharmacy Clinical Help Desk at 1-800-437-3803.

PATIENT INFORMATION	PHYSICIAN INFORMATION
Name	**Name**
ID number	**Specialty**
Date of birth ☐ Male ☐ Female	**Address**
Diagnosis	**City/State/ZIP**
Drug name/HCPCS code	**Phone**: ( ) - **Fax**: ( ) -
Dose and quantity	**NPI**
Directions	**Contact person**
Date of services	**Contact person's phone/ext.**

Step 1: DISEASE STATE INFORMATION

1. Is this request for: ☐ Initiation ☐ Continuation Date of last dose: _____
2. Place of service: ☐ Home ☐ Outpatient (NPI _____) ☐ Office
3. Height: _____ Weight (kg): _____
4. **For Prolia® or Evenity® requests (if applicable)**:
   Previous bisphosphonate therapy? Name of drug (s)_____ Dates: _____
   DXA scan T-scores: Left hip: _____ Right hip: _____ Left or right forearm:_____ Spine_____
   10-year probability of hip fracture _____% Major osteoporosis-related fracture _____% (DXA REPORT MUST BE ATTACHED)
5. For **immune globulin (IVIG)** request (if applicable): IgG level_____ mg/dL Date:_____
6. For certain **asthma drugs** (if applicable): IgE level_____Date:_____ Eosinophil level_____Date:_____
7. For **retinal medications** (if applicable): Which eye is being treated? ☐ Left ☐ Right: ☐ Both
   Has the patient tried and failed Avastin®? ☐ Yes: Which eye(s)?_____ Dates:_____ ☐ No
8. Please provide other relevant history or information for the medication you are requesting:

   _____

   _____

   _____

   _____

9. Attach any chart notes or additional documentation and submit to plan. (***Required***)

Coverage won't be provided if the prescribing physician's signature and date aren't included on this document.

☐ Request for **expedited review**: Please only check this option if the provider believes that waiting for the standard time frame **could place the enrollee's life, health or ability to regain maximum function in serious jeopardy. (CMS definition)**

Physician's name	**Physician signature**	**Date**

Step 2: Checklist	☐ Completed form ☐ Attached chart notes	☐ Concurrent medical problems ☐ Prior therapies
Step 3: Submit	**Fax the completed form to 1-866-392-6465.**	

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