Blue Cross Blue Shield Blue Care Network of Michigan

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Blue Cross Medicare Plus Blue℠ PPO and BCN Advantage℠
Medication Authorization Request Form
Hemlibra® (emicizumab-kxwh) J7170

The most efficient way to request authorization is to use the NovoLogix® system. To access NovoLogix, visit bcbsm.com/providers and log in to Provider Secured Services. Click the link for Medical Prior Authorization. As an alternative, you can use this form to request authorization. Complete this form and fax to 1-866-392-6465. If you have any questions regarding this process, 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 (include ICD-10)	**City /State/Zip**
Drug Name	**Phone:** ( ) - **Fax:** ( ) -
Dose and Quantity	**NPI**
Directions	**Contact Person**
Date of Services	**Contact Person's Phone / Ext.**

STEP 1: DISEASE STATE INFORMATION

1. Initial or Continuation request? ☐ Initial ☐ Continuation, start date of therapy._____
2. Is the patient being treated by or in consultation with a hematologist? ☐ Yes ☐ No
3. Is Hemlibra® being dispensed at a hemophilia treatment center? ☐ Yes ☐ No. Please specify why not.

   _____
4. What is the patient's diagnosis? ☐ Hemophilia A with inhibitors ☐ Hemophilia A without inhibitors ☐ Other. Please specify

   _____
5. Does the patient have a current or previous high titer inhibitor for factor VIII? ☐ Yes. What was the level? _____ ☐ No
6. Will the patient be getting immune tolerance while on Hemlibra®? ☐ Yes. With what agent? _____ ☐ No
7. For patients with Hemophilia A without inhibitors how is it classified?
   ☐ Mild. What is the Factor VIII level? _____ ☐ Moderate. What is the Factor VIII level? _____ ☐ Severe. What is the Factor VIII level? _____
8. Has optimally dosed therapy with prophylactic factor VIII products been ineffective for prevention of spontaneous bleeding events?
   ☐ Yes. What product was used?
   ☐ No

FOR CONTINUATION REQUESTS:

9. Has the patient experienced a decreased number of bleeds since beginning prophylaxis with Hemlibra ®? ☐Yes ☐ No
10. For initiation and continuation requests, please 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 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's Signature** **Date**

Step 2: Checklist	☐ Form Completely Filled Out ☐ Attached Chart Notes	☐ Concurrent Medical Problems ☐ Prior Therapies
Step 3: Submit	**Fax the completed form to 1-866-392-6465**	