Blue Cross Blue Shield Blue Care Network of Michigan

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Medicare Plus Blue℠ PPO and BCN Advantage℠
Medication Authorization Request Form
KANUMA® (Sebelipase alfa) J2840

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 and fax this form 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**
D.O.B. ☐ 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. Is this an initial request or continuation of therapy?
   ☐ Initial request (go to # 2) ☐ Continuation (go to # 2)

2. What is the patient's diagnosis?
   ☐ Lysosomal acid lipase deficiency (LAL-d)
   ☐ Other, please specify medical diagnosis _____

3. How has the patient been diagnosed with lysosomal acid lipase deficiency? ***(Please attach any tests confirming diagnosis)***
   ☐ Diagnosis of lysosomal acid lipase deficiency was confirmed by blood test measuring LAL activity
   ☐ Diagnosis of lysosomal acid lipase deficiency was confirmed by genetic testing
   ☐ Unknown ☐ Other. Please specify other diagnositic tool utilized _____

4. Which of the following clinical manifestations of lysosomal acid lipase deficiency (LAL-d) is the patient presenting with? Please select all that apply.
   ☐ Elevated liver enzymes ☐ Microvesicular steatosis ☐ Elevated low-density lipoprotein
   ☐ Low high-density lipoprotein ☐ Coronary artery disease ☐ None
   ☐ Other. Please provide the clinical manifestation the patient is presenting with _____

5. Has the patient experienced improvement while on enzyme replacement therapy documented in the chart notes?
   ☐ Yes ☐ No

6. 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	☐ Completed form ☐ Attached chart notes	☐ Diagnostic tests attached
Step 3: Submit	**Fax the completed form to 1-866-392-6465.**	

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