Blue Cross Blue Shield Blue Care Network of Michigan

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

Blue Cross Medicare Plus Blue℠ PPO and BCN Advantage℠
Medication Authorization Request Form
Oncology Biosimilars
Avastin® (J9035), Herceptin® (J9355), Ogivri® (Q5114), Herzuma® (Q5122), Ontruzant® (Q5112), Rituxan® (J9312), Truxima® (Q5115)

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. Is the requested drug being used to treat an FDA-approved indication? ☐ Yes. Diagnosis_____
   ☐ No. Diagnosis._____
2. Please select the preferred Avastin biosimilar to which the patient has experienced an intolerance, or contraindication, or adverse event for the requested indication.

   ☐ Mvasi™ ☐ Zirabev® ☐ Other_____
3. Please select the preferred Herceptin biosimilar to which the patient has experienced an intolerance, or contraindication, or adverse event for the requested indication.

   ☐ Trazimera™ ☐ Kanjinti™ ☐ Other_____
4. Please select the preferred Rituxan biosimilar to which the patient has experienced an intolerance, or contraindication, or adverse event for the requested indication.

   ☐ Ruxience® ☐ Riabni™ ☐ Other_____
5. 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 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**	