Blue Cross Blue Shield Blue Care Network of Michigan

Blue Cross Medicare Plus Blue℠ PPO and BCN Advantage℠ Medication Authorization Request Form Onpattro™ (patisiran) J0222

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**
D.O.B. ☐Male ☐Female	**Address**
Diagnosis (include ICD-10)	**City /State/Zip**
Drug Name	**Phone/Fax: P**: ( ) - **F**: ( ) -
Dose and Quantity	**NPI**
Directions	**Contact Person**
Date of Services	**Contact Person Phone / Ext.**

STEP 1: DISEASE STATE INFORMATION

1. Initial or Continuation request? ☐ Initial ☐ Continuation Original Start date _____
2. What is the patients diagnosis:
   ☐ Polyneuropathy caused by hereditary transthyretin-mediated amyloidosis (hATTR amyloidosis)
   ☐ Other: _____
3. Does the patient have a documented TTR mutation? ☐ Yes ☐ No
4. What signs and symptoms of peripheral neuropathy does the patient exhibit?
   ☐ Tingling or increased pain in the hands, feet and/or arms ☐ Loss of feeling in the hand and/or feet
   ☐ Numbness or tingling in the wrists ☐ Carpel tunnel syndrome ☐ Loss of ability to sense temperature
   ☐ Difficulty with fine motor skills ☐ Weakness in the legs or difficulty walking ☐ Orthostasis
   ☐ Abnormal sweating ☐ Dysautonomia (constipation and/or diarrhea, nausea, vomiting, anorexia, early satiety)
   ☐ Other: _____
5. Will Onpattro be used in combination with Oligonucleotide agents (such as: inotersen) or TTR stabilizers (such as: tafamidis)? ☐ Yes ☐ No
6. For continuation: Please describe the clinical response to Onpattro as documented in the office notes:
   ☐ Positive clinical response (such as: improved neurological impairment, motor function, cardiac function, quality of life assessment)
   ☐ Stabilization or improvement in serum TTR levels ☐ Stabilization or improvement of FAP stage from baseline
   ☐ Stabilization or improvement of PND score from baseline ☐ Condition gotten worse ☐ Other: _____
7. 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	☐ Completed form ☐ Attached Chart Notes	☐ Attached diagnostic tests
Step 3: Submit	**FAX the completed form to 1-866-392-6465**	

Updated: 10-01-19, 11/25/18