Blue Cross Blue Shield Blue Care Network of Michigan

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Medicare Plus Blue℠ PPO and BCN Advantage℠ Medication Authorization Request Form Zilretta® (triamcinolone acetonide extended-release injection) J3304

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**
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
2. What is the patient's diagnosis? ☐ Osteoarthritis pain of the knee ☐ Other, please specify diagnosis: _____
3. Has the patient been treated with any of the following agents? Select all that apply: ☐ Oral NSAID (i.e. Ibuprofen, naproxen). Please specify NSAID used: _____ ☐ Topical NSAID. Please specify topical NSAID used: _____ ☐ Other, please list therapy use: _____
4. Is the patient unable to take oral NSAIDS? ☐ Yes, please specify reason unable to take oral NSAIDS: _____ ☐ No
5. Has the patient had an intra-articular triamcinolone acetonide injection? ☐ Yes. Date of injection: _____ ☐ No
6. What was the response to the intra-articular triamcinolone acetonide injection? Select all that apply: ☐ Adequate pain relief ☐ Frequent need for rescue doses of oral NSAIDs (inadequate pain relief) ☐ Unable to maintain or increase activity level ☐ Adequate pain relief, but experienced steroid-induced hyperglycemia
7. 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	☐ Concurrent medical problems ☐ Prior therapies
Step 3: Submit	**Fax the completed form to 1-866-392-6465**	