

Follow these steps to submit prior authorization requests when prescribing drugs covered under the medical benefit for Blue Cross Blue Shield of Michigan and Blue Care Network commercial members.

Michigan prescribers

To submit prior authorization requests electronically, first register for Availity® Essentials, our provider portal; refer to the [Register for web tools](#) page at bcbsm.com for details. Then:

1. Log in to [availity.com](#)*.
2. Click *Payer Spaces* on the menu bar and click the BCBSM and BCN logo.
3. On the Applications tab, click the tile for the appropriate NovoLogix web tool.
4. Within NovoLogix, click the *Authorizations* menu and select *Create Authorization*.
5. Enter the member's details and select the correct member on the contract.
6. Complete the required fields. This includes selecting the correct drug in the "Authorization Lines" section.
7. Click *Submit*, complete the protocol questions and click *Done*.

If you're registered for Availity but are not able to access it, submit your prior authorization request using the *Medication Authorization Request Form*, or MARF, that's on the next page.

Non-Michigan prescribers

When submitting a prior authorization request for the first time, prescribers located outside of Michigan should complete and submit:

- The *Medication Authorization Request Form*, or MARF, that's on the next page
- The [Application for access to NovoLogix for non-Michigan prescribers](#)

Submit these documents to the fax number or address that's on the MARF. Once we approve the request for access, we'll provide information about how to access the NovoLogix tool so that you can submit subsequent prior authorization requests electronically.

Note: Access to NovoLogix is available only to registered users. You must include a valid Type 1 (individual) NPI on the application for access to NovoLogix.

Information about NovoLogix

For more information about the NovoLogix web tool, look under the Training Resources heading on these webpages:

- [Blue Cross Medical-Benefit Drugs](#)
- [BCN Medical-Benefit Drugs](#)

If you need help with the NovoLogix tool, contact the Web Support Help Desk at 1-877-258-3932.

*Clicking this link means that you're leaving the Blue Cross Blue Shield of Michigan and Blue Care Network website. While we recommend this site, we're not responsible for its content.

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Blue Cross Blue Shield/Blue Care Network of Michigan
Medication Authorization Request Form
Cinqair® (reslizumab) HCPCS CODE: J2786



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This form is to be used by participating physicians to obtain coverage for Cinqair®. For commercial members only, please complete this form and submit via fax to 1-877-325-5979. If you have any questions regarding this process, please contact BCBSM Provider Relations and Servicing or the Medical Drug Helpdesk at 1-800-437-3803 for assistance.

PATIENT INFORMATION	PHYSICIAN INFORMATION
Name	Name
ID Number	Specialty
D.O.B. <input type="checkbox"/> Male <input type="checkbox"/> Female	Address
Weight (kg): _____ Date recorded: _____	
Diagnosis	City /State/Zip
Drug Name <input type="checkbox"/> Cinqair	Phone/Fax: P: () - F: () -
Dose and Quantity	NPI
Directions	Contact Person
Date of Service(s)	Contact Person Phone / Ext.

STEP 1: DISEASE STATE INFORMATION

- Is this request for: ☐ Initiation ☐ Continuation **Date patient started therapy:** _____
- Site of administration? ☐ Provider office/Home infusion ☐ Other: _____
☐ Hospital outpatient facility (go to #3) **Reason for Hospital Outpatient administration:** _____
- Please specify location of administration if hospital outpatient infusion:** _____
- Please provide the NPI number for the place of administration:** _____
- Initiation AND Continuation of therapy:**
 - Please check the patient's diagnosis: ☐ Severe eosinophilic asthma (EA)
☐ Other: _____
 - What is the patient's blood eosinophil level at the initiation of therapy in cells/microliter? _____ Date of Result: _____
 - Which treatment(s) did not adequately control the patient's EA after a trial of at least 3 months?

<input type="checkbox"/> Systemic corticosteroid: _____	Date: Start: _____ End: _____
<input type="checkbox"/> High dose inhaled corticosteroids: _____	Date: Start: _____ End: _____
<input type="checkbox"/> Long acting beta2-agonist: _____	Date: Start: _____ End: _____
<input type="checkbox"/> Leukotriene receptor antagonist: _____	Date: Start: _____ End: _____
<input type="checkbox"/> Combination asthma inhaler with a HIGH dose corticosteroid and a long acting beta agonist: _____	Date: Start: _____ End: _____
<input type="checkbox"/> Combination asthma inhaler with a MEDIUM dose corticosteroid and a long acting beta agonist: _____	Date: Start: _____ End: _____
<input type="checkbox"/> Long acting muscarinic antagonist (LAMA): _____	Date: Start: _____ End: _____
<input type="checkbox"/> Other: _____	Date: Start: _____ End: _____
 - Please select the preferred product(s) the patient has tried for at least 4 months and experienced treatment failure, intolerance, or contraindication the requested indication.
☐ Nucala ☐ Fasenra ☐ Dupixent ☐ Tezspire ☐ Other: _____
 - Is the patient currently receiving and will continue to receive a standard of care regimen for their diagnosis with Cinqair?
☐ Yes ☐ No Comment: _____
 - Will the patient be using Cinqair in combination with other biologic asthma agents (for example: Xolair, Nucala, Fasenra, or Tezspire)?
☐ Yes ☐ No Comment: _____
- Continuation request:** (please answer above questions as well): **Cinqair start date:** _____
 - Have the patient's signs and symptoms improved with Cinqair?
☐ Yes ☐ No, Comment: _____ ☐ Other: _____

Please add any other supporting medical information necessary for our review

Coverage will not be provided if the prescribing physician's signature and date are not 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	<input type="checkbox"/> Form Completely Filled Out <input type="checkbox"/> Attach Chart Notes	<input type="checkbox"/> Attach Diagnostic Tests
Step 3 Submit	By Fax: BCBSM Specialty Pharmacy Mailbox 1-877-325-5979	By Mail: BCBSM Specialty Pharmacy Program P.O. Box 312320, Detroit, MI 48231-2320

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