Blue Cross Blue Shield Blue Care Network of Michigan

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

How to submit prior authorization requests for medical benefit drugs

For Blue Cross commercial and Blue Care Network commercial

April 2023

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

Hereditary Angioedema - Berinert® (C1 Esterase Inhibitor) J0597, Cinryze® (C1 Esterase Inhibitor) J0598, Kalbitor® (ecallantide) J1290, Firazyr® (icatibant) J1744, Ruconest® (C1 Esterase Inhibitor) J0596, Sajazir (icatibant acetate) J1744

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This form is to be used by participating physicians to obtain coverage for Hereditary Angioedema Medications. 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. ☐Male ☐Female **Pt weight (in kg)** **Date recorded:**_____	**Address**
Diagnosis	**City /State/Zip**
Drug Name	**Phone/Fax: P**: ( ) - **F**: ( ) -
Dose and Quantity	**NPI**
Directions	**Contact Person**
Date of Service(s)	**Contact Person Phone / Ext.**

STEP 1: **DISEASE STATE INFORMATION**

1. Is this for Initiation or Continuation of therapy? ☐ Initiation ☐ Continuation *Date patient started therapy:* _____
2. Which product is being requested?
   ☐ Brand product (Berinert, Ruconest, Kalbitor, Firazyr) ☐ Generic product (Icatibant: generic Firazyr) ☐ Sajazir
3. Who is administering this medication? ☐ Self-administration ☐ Health Care Professional
4. Site of administration? ☐ Provider office/Home infusion ☐ Other: _____
   ☐ Hospital outpatient facility (go to #4) *Reason for Hospital Outpatient administration*: _____
5. Please specify location of administration if hospital outpatient infusion: _____
6. Please provide the NPI number for the place of administration: _____

7. **Initiation AND Continuation of therapy:**
   a. Please check the patient's diagnosis: ☐ Hereditary Angioedema (HAE) ☐ Other: _____
   b. What type of Hereditary Angioedema does the patient have?
      ☐ Type 1 ☐ Type 2 ☐ Type 3 ☐ Other: _____
   c. How was the diagnosis of HAE confirmed? Note: values defined by the laboratory performing the test
      ☐ Normal C1q level, Please provide results: _____
      ☐ C4 levels below the lower limit of normal, Please provide results: _____
      ☐ C1INH antigenic level: Low, C1INH function: not fully functional, Please provide results: _____
      ☐ C1INH antigenic level: Normal/elevated, C1INH function: not fully functional, Please provide results: _____
      ☐ Other; Please list alternative test used to confirm diagnosis AND how it confirms the diagnosis: _____
   d. What is the primary indication this medication is being used to treat?
      ☐ Treatment of acute attack ☐ Long-term prophylaxis
      ☐ Short term prophylaxis ☐ Other: _____
   e. Please select which of the following applies to the patient and their need for short-term hereditary angioedema prophylaxis:
      ☐ Dental work ☐ Surgical procedures
      ☐ Invasive medical procedures ☐ Other: _____
   f. Does the patient have a history of attacks that are considered severe with swelling of the face, throat or gastrointestinal tract? ☐ Yes ☐ No
      i. If no, how many HAE attacks does the patient have per month? _____/month.
   g. ***Cinryze only for patients ≥ 12 years old:***
      Which of the following agents has the patient experienced treatment failure with for their condition?
      ☐ Haegarda ☐ Takhzyro ☐ Other, Please list name of the agent: _____
   h. **For Berinert, Ruconest, Kalbitor, Sajazir and Firazyr only:** Has the patient experienced treatment failure with GENERIC Firazyr® (icatibant) for treatment of acute attacks?
      ☐ Yes, Please specify how the patient failed icatibant therapy (for example: side effects, lack of efficacy, etc.): _____
      ☐ No
   i. ***Ruconest only***: Has the patient had laryngeal attacks from hereditary angioedema (HAE)? ☐ Yes ☐ No
   j. Will the patient be using the drug requested in combination with other products indicated for acute hereditary angioedema (HAE) attacks (for example: Kalbitor, Berinert, Firazyr, Ruconest, or icatibant)? ☐ Yes ☐ No
   k. Will the patient be on prophylactic therapy (for example: Haegarda, Takhzyro, or Cinryze, etc.) for hereditary angioedema (HAE) if they have exceeded the total monthly quantity allowed, as defined by the BCBSM medical policy for acute HAE? ☐ Yes ☐ No

8. **Continuation of therapy: (please fill out above questions as well)**
   a. Has the patient demonstrated at least a 50% improvement of acute attacks symptoms and maintenance of symptoms? ☐ yes ☐ no
   b. For long term prophylaxis, how has the patient improved?
      ☐ 50% or greater reduction in HAE attacks ☐ Reduction in duration of attack ☐ Reduction in days of swelling ☐ 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	☐ Form Completely Filled Out ☐ Attached Chart Notes	☐ Concurrent Medical Problems ☐ Prior Therapies
Step 3: Submi	**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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