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

Remicade® (infliximab) J1745, infliximab J1745, Inflectra™ (infliximab-dyyb) Q5103, Renflexis™ (infliximab-abda) Q5104, Avsola™ (infliximab-axxq) Q5121

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This form is to be used by participating physicians to obtain coverage for Remicade, Inflectra, Renflexis, and Avsola. 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	**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. Initiation or Continuation of therapy? ☐ Initiation ☐ Continuation *Date patient started therapy:* _____
2. Site of administration? ☐ Provider office/Home infusion ☐ Other: _____
   ☐ Hospital outpatient facility (go to #3) *Reason for Hospital Outpatient administration:* _____
3. **Please specify location of administration if hospital outpatient infusion:** _____
4. **Please provide the NPI number for the place of administration:** _____
5. What is the Patient's weight in Kg? _____ Date recorded: _____
6. Primary Indication: ☐ Crohn's Disease **(See #7b)** ☐ Ulcerative Colitis **(See #7b)** ☐ Rheumatoid Arthritis **(See #7c)**
   ☐ Psoriatic Arthritis ☐ Plaque psoriasis **(See #7d)** ☐ Ankylosing spondylitis
   ☐ Generalized pustular psoriasis as defined by the European Rare and Severe Psoriasis Expert Network
   ☐ Other: _____
7. **Initiation AND Continuation of therapy**:
   a. Will the patient be receiving Remicade/Inflectra/Renflexis/Avsola with other biologic agents (for example: Humira, Kineret, Entyvio, or Tremfya, etc.) or with targeted DMARD medications (for example: Otezla)? ☐ Yes ☐ No, Comment:_____
   b. **Crohn's Disease AND Ulcerative colitis**
      i. Does the patient have Crohn's disease with fistula? ☐ Yes ☐ No
      ii. Which therapies has the patient tried and failed?
      ☐ Systemic corticosteroids (e.g. 40 to 60 mg prednisone, prednisolone) daily for 7 days
      ☐ Immunomodulatory therapy for at least 2 months (e.g. azathioprine, mercaptopurine, or methotrexate)
      ☐ None ☐ Other: _____
   c. **Rheumatoid Arthritis (RA:**
      iii. Has the patient had documented failure of at least 3 months of an oral DMARD? (e.g. hydroxychloroquine, methotrexate, leflunomide, or sulfasalazine)
      ☐ Yes, Length of therapy: _____ ☐ No
      iv. Will the patient be taking infliximab in combination with methotrexate? ☐ Yes ☐ No, Provide rationale: _____
   d. **Plaque Psoriasis**:
      i. Has the patient experienced treatment failure with one topical corticosteroid?
      ☐ Yes, Please list topical corticosteroids the patient has tried: _____
      ☐ No, Comment: _____
8. Which medication has the patient tried and failed at optimized dose? ☐ Inflectra ☐ Avsola ☐ Other: _____
   a. What was the maximum dose the patient received of Inflectra in mg/kg and frequency? _____
   b. What was the maximum dose the patient received of Avsola in mg/kg and frequency? _____
   c. How has the patient failed Inflectra and Avsola therapy?
   ☐ Hypersensitivity reaction (for example: hives during infusion), Please specify: _____
   ☐ Side effects, Please specify: _____
   ☐ Lack of efficacy (for example: abdominal pain, bloody stools, etc.), Please specify: _____
   ☐ Other, Please specify: _____
9. **Continuation Request:** Remicade/Inflectra/Renflexis/Avsola Start Date _____
   a. Has the patient's signs and symptoms improved with Remicade/Inflectra/Renflexis/Avsola? ☐ Yes ☐ No Comment: _____

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
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**

1/31/2020; 7/1/2020; 2/4/2021; 12/9/2021; 10/7/2022