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

Blue Cross Blue Shield Blue Care Network of Michigan

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Immune Globulin Replacement Therapy - Bivigam® (J1556), Carimune NF® (J1566), Cuvitru™ (J1555), Flebogamma® (J1572), Gammagard® (J1569), Gammaplex® (J1557), Gamunex® (J1561), Gammaked (J1561), Hizentra® (J1559), HyQvia® (J1575), Octagam® (J1568), Privigen® (J1459), Ig NOS (J1599) Panzyga® (J1599), Cutaquig® (J1551), Asceniv™ (J1554), Xembify (J1558)

This form is to be used by participating physicians to obtain coverage for immune globulin products. 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 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) **Initial or Continuation of therapy?** ☐ Initial ☐ Continuation ***Original Start date:*** _____

2) **How administered?** ☐ Self-administered ☐ Health care professional administered

3) Site of administration? ☐ Provider office/Home infusion ☐ Other: _____
☐ Hospital outpatient facility (go to #4) *Reason for Hospital Outpatient:* _____

4) Please provide the NPI number for the place of administration: _____

5) Please specify location of administration if hospital outpatient infusion? _____

6) Please provide the member's current weight (in kilograms) and height (in inches): _____

7) **Indication:** ☐ Primary Humoral Immunodeficiency Diseases Type: _____ ☐ Acute IDP (Guillain Barre)
☐ Chronic Inflammatory Demyelinating Polyneuropathy (IDP) ☐ Multifocal Motor Neuropathy
☐ Solid Organ Transplant ☐ Dermatomyositis ☐ Multiple myeloma ☐ Hypogammaglobulinemia
☐ Idiopathic Thrombocytopenic Purpura (ITP) ☐Chronic ☐ Acute ☐ Pregnancy ☐ HIV ☐ Bone Marrow Transplant
☐ Myasthenia Gravis ☐ Systemic Lupus Erythematosus ☐ Polymyositis ☐ Other_____

8) **Please fill out what pertains to patient AND give level:**

Test	Response	Levels	Date	Test	Response	Levels	Date
IgG	☐ low ☐ normal ☐ high	_____	_____	IgD	☐ low ☐ normal ☐ high	_____	_____
IgM	☐ low ☐ normal ☐ high	_____	_____	B cells	☐ low ☐ normal ☐ high	_____	_____
IgA	☐ low ☐ normal ☐ high	_____	_____	T cells	☐ low ☐ normal ☐ high	_____	_____
IgE	☐ low ☐ normal ☐ high	_____	_____	Platelet count _____/mm^3 Date: _____			

9) **Please check which boxes pertain to patient:** ☐ Unable to produce response to: ☐ protein antigen ☐carbohydrate antigen
☐ Recurrent infections ☐ Prophylactic Antibiotics ☐ Immunization with conjugate vaccine

10) **Please list past trials and failures of other conventional therapies:**

Prior Therapy	Dates of Therapy	Outcome/Reason for D/C
_____	_____ to _____	☐ Not tolerated ☐ Failure Explain: _____
_____	_____ to _____	☐ Not tolerated ☐ Failure Explain: _____
_____	_____ to _____	☐ Not tolerated ☐ Failure Explain: _____

11) **For continuation, check all that applies to response to therapy (please provide and attach applicable lab values)**
☐ Improved Please describe: _____
☐ Stable Please describe: _____
☐ Worse Please describe: _____
☐ No assessment available on file; Explain: _____

Chart notes are required for the processing of all requests. Please add any other supporting medical information.

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: 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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