

# 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**  
**Lemtrada® (alemtuzumab) HCPCS CODE: J0202**



This form is to be used by participating physicians to obtain coverage for Lemtrada®. 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
<b>Name</b>	<b>Name</b>
<b>ID Number</b>	<b>Specialty</b>
<b>D.O.B.</b> <span style="float:right;"><input type="checkbox"/> Male <input type="checkbox"/> Female</span>	<b>Address</b>
<b>Patient weight (in kg)</b> <span style="float:right;">Date recorded: _____</span>	
<b>Diagnosis</b>	<b>City /State/Zip</b>
<b>Drug Name</b>	<b>Phone/Fax: P: (     )     -     F: (     )     -</b>
<b>Dose and Quantity</b>	<b>NPI</b>
<b>Directions</b>	<b>Contact Person</b>
<b>Date of Service(s)</b>	<b>Contact Person Phone / Ext.</b>

**STEP 1: DISEASE STATE INFORMATION**

1. Initiation or Continuation of treatment? ☐ 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: \_\_\_\_\_*
3. Please specify location of administration if hospital outpatient infusion: \_\_\_\_\_
4. Please provide the NPI number for the place of administration: \_\_\_\_\_
5. Indicate which course of therapy this request is for? ☐ First course ☐ Second course ☐ Third or more course
6. **Initiation AND Continuation of Therapy:**
  - a. Please check the patient's diagnosis:
☐ Relapsing-Remitting Multiple Sclerosis (RRMS)  
☐ Active Secondary Progressive multiple sclerosis  
☐ Other: \_\_\_\_\_
7. **Continuation Request** (please answer questions above as well): Lemtrada start date: \_\_\_\_\_
  - a. How has the patient improved while on Lemtrada? (check all that apply)
☐ Slowing of disability progression  
☐ No new T1/T2 lesions  
☐ Decrease in frequency of relapses  
☐ Improvement in disability  
☐ Other: \_\_\_\_\_
8. Will the patient be using Lemtrada used in combination with other disease-modifying treatments for multiple sclerosis (MS) (for example: Ocrevus)?  
☐ Yes, comment: \_\_\_\_\_ ☐ No

**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
<b>Step 2:</b> Checklist	<input type="checkbox"/> Form Completely Filled Out <input type="checkbox"/> Attached Chart Notes	<input type="checkbox"/> Concurrent Medical Problems <input type="checkbox"/> Prior Therapies
<b>Step 3:</b> Submit	<b>By Fax: BCBSM Specialty Pharmacy Mailbox 1-877-325-5979</b>	<b>By Mail: BCBSM Specialty Pharmacy Program P.O. Box 312320, Detroit, MI 48231-2320</b>

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4/9/2015; 11/20/2015; 8/11/2017; 2/2/2018;10/11/2018; 2/26/2020