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.

Availity® is an independent company that contracts with Blue Cross Blue Shield of Michigan and Blue Care Network to offer provider portal services.

Blue Cross Blue Shield/Blue Care Network of Michigan
Medication Authorization Request Form
Prolia™ HCPCS CODE: J0897

Blue Cross Blue Shield Blue Care Network of Michigan

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This form is to be used by participating physicians to obtain coverage for Prolia™. 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 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 administration:* _____
3. **Please specify location of administration if hospital outpatient infusion:** _____
4. **Please provide the NPI number for the place of administration:** _____

5. **Initiation and Continuation:**
   a. Will the patient be using Prolia in combination with any anabolic bone modifying agent (for example: Forteo, Tymlos) or bisphosphonate (for example: Fosamax)?
      ☐ Yes ☐ No Comment _____
   b. Primary Indication: ☐ Osteoporosis ☐ Osteopenia ☐ High risk for fracture ☐ Prevention of skeletal related events ☐ Other _____
   c. Type of cancer: ☐ Breast cancer ☐ Prostate cancer ☐ No cancer diagnosis ☐ Other: _____
   d. Endocrine therapy: ☐ Androgen deprivation therapy ☐ Aromatase inhibitor therapy ☐ Other: _____
   e. Please complete the chart below with the patient's **T-scores** (Please provide DEXA scan results)**:**

	Example	**Before bisphosphonate**	**During bisphosphonate**	**Before Prolia**	**During Prolia**
Date of scan	*12/15/2019*				
Spine T-score	*-2.5*				
Left Hip T-score	*-2.7*				
Right Hip T-score	*-2.3*				

   f. 10-year probability of hip fracture _____% major osteoporosis-related fracture _____%
   g. Has the patient had a non-traumatic fracture? ☐ Yes, please provide the date and location of the fracture: _____ ☐ No
   h. What is the patient's creatine clearance? _____ mL/min Date: _____
   i. Has the patient tried and failed bisphosphonates for at least 12 months?
      ☐ Yes, please provide the medication failed and dates by filling the table below (j) ☐ No, please state why?: _____
   j. Check the bisphosphonate(s) the patient received and dates of therapy and response to therapy:

Bisphosphonates	Dates of therapy	Outcome / Reason for Discontinuation
☐ Reclast/Zometa (zoledronic acid)	***Start:*** _____ ***End:*** _____	☐ Not tolerated ☐ Failure Explain: _____
☐ Aredia (pamidronate)	***Start:*** _____ ***End:*** _____	☐ Not tolerated ☐ Failure Explain: _____
☐ Boniva (ibandronate) ☐**IV** ☐**PO**	***Start:*** _____ ***End:*** _____	☐ Not tolerated ☐ Failure Explain: _____
☐ Fosamax (alendronate)	***Start:*** _____ ***End:*** _____	☐ Not tolerated ☐ Failure Explain: _____
☐ Actonel (risedronate)	***Start:*** _____ ***End:*** _____	☐ Not tolerated ☐ Failure Explain: _____
☐ Other _____	***Start:*** _____ ***End:*** _____	☐ Not tolerated ☐ Failure Explain: _____

6. **Continuation request** (please answer above questions as well): **Prolia start date:** _____
   a. Check all that applies for response to Prolia therapy (continuation only)
      Skeletal related events: ☐ None ☐ Radiation to bone ☐ Surgery to bone ☐ Pathologic fracture ☐ Spinal cord compression
      Fractures: ☐ None ☐ Osteoporotic Fractures ☐ Major Bone Fracture ☐ Unchanged CSC ☐ Other _____
   b. Please include an updated BMD test and provide T-score values on the chart **above (5d)**

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 ☐ BMD (prior to and after Prolia)	☐ Prior Trials (bisphosphonates) ☐ Concurrent medical problems ☐ Calcium level
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**

1/28/2016; 7/8/2016; 2/2/2018; 7/23/2018, 9/18/2018; 8/1/2019; 1/6/2020; 3/17/2020; 10/20/2021; 10/6/2022, 06/01/2023