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
Signifor® LAR (pasireotide) HCPCS CODE: J2502

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This form is to be used by participating physicians to obtain coverage for Signifor LAR. 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 medication being administered by: ☐ Self (patient) ☐ Health care professional (physician/nurse)
2. Is the patient being seen by an Endocrinologist? ☐ yes ☐ no Specialty: _____
3. What is the patient's dose and frequency of requested therapy? _____
4. Is this request for: ☐ Initiation ☐ Continuation ***Original start date:*** _____
5. **Initiation AND Continuation of therapy:**
   a. Please check the patient's diagnosis: ☐ Acromegaly ☐ Cushings Disease
      ☐ Hormone secreting tumors of the GI tract ☐ Other: _____
   b. Has the patient had a poor response to surgery and/or is surgery not an option for them?
      ☐ yes ☐ no; Please explain: _____
   c. Does the patient have elevated insulin-like growth factor-1 (IGF-1)? *(Before treatment started)*
      ☐ yes, current level _____, date drawn: _____ ☐ no
   d. Please check which medications the patient has tried:
      ☐ Somatuline Depot ☐ Sandostatin
      ☐ Sandostatin LAR ☐ Somavert ☐ Other: _____
6. **Continuation request:** Signifor LAR start date: _____
   a. Has the patient had improvement in manifestations of acromegaly?
      ☐ yes ☐ no; Please explain: _____
   b. If the patient has improvement in manifestations of acromegaly, please check which apply:
      ☐ Decrease in Growth Hormone (GH) and/or IGF-1 levels
      ☐ Decrease in pituitary tumor size
      ☐ Other, explain: _____
7. Please attach any chart notes or additional documentation and submit to plan. ***(Required)***

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	☐ Patient and Physician Information complete
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**

9/22/2015; 11/20/2015; 2/2/2018;10/11/2018