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
Tezspire™ (tezepelumab-ekko)
HCPCS CODE: J2356

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This form is to be used by participating physicians to obtain coverage for Tezspire™. 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. Is this request for: ☐ Initiation ☐ Continuation ***Date patient started therapy***: _____
2. Is this request for self or office administration? ☐ Self- administration ☐ Office administration
   a. If office, please provide the NPI number for the place of administration: _____
3. **Initiation AND Continuation of therapy:**
   a. Please check the patient's diagnosis**:** ☐ Severe asthma **(go to b)** ☐ Other: _____
      ☐ Severe eosinophilic asthma (**EA, go to b, c and d**)
      ☐ Allergic asthma **(go to b and e)**
      ☐ Oral corticosteroid dependent phenotype **(OCS, go to b and d)**
   b. Which treatment(s) did not adequately control the patient's severe asthma, EA, allergic asthma, or OCS dependent symptoms after a trial of at least 3 months?
      ☐ Systemic corticosteroid: _____ Date: *Start:* _____ *End:* _____
      ☐ High dose inhaled corticosteroids: _____ Date: *Start:* _____ *End:* _____
      ☐ Long acting beta2-agonist: _____ Date: *Start:* _____ *End:* _____
      ☐ Leukotriene receptor antagonist: _____ Date: *Start:* _____ *End:* _____
      ☐ Combination asthma inhaler with a HIGH dose corticosteroid and a long acting beta agonist: _____ Date: *Start:* _____ *End:* _____
      ☐ Combination asthma inhaler with a MEDIUM dose corticosteroid and a long acting beta agonist: _____ Date: *Start:* _____ *End:* _____
      ☐ Long acting muscarinic antagonist (LAMA): _____ Date: *Start:* _____ *End:* _____
      ☐ Other: _____ Date: *Start:* _____ *End:* _____
   c. **EA:** Please select the preferred product(s) the patient has tried for at least 4 months and experienced intolerance, contraindication, or adverse event for the requested indication.
      ☐ Nucala ☐ Fasenra ☐ Dupixent ☐ Other: _____
   d. **EA and OCS dependent asthma:** Please select the preferred product(s) the patient has tried for at least 4 months and experienced intolerance, contraindication, or adverse event to for the requested indication.
      ☐ Dupixent ☐ Other: _____
   e. **Allergic asthma:** Please select the preferred product(s) the patient has tried for at least 4 months and experienced intolerance, contraindication, or adverse event to for the requested indication.
      ☐ Xolair ☐ Other: _____
   f. Will the patient be using Tezspire in combination with other biologic agents (for example: Xolair, Nucala, Cinqair, or Fasenra)?
      ☐ Yes ☐ No Comment: _____
   g. Is the patient currently receiving and will continue to receive a standard of care regimen for their diagnosis with Tezspire?
      ☐ Yes ☐ No Comment: _____
4. **Continuation request:** (please answer above questions as well): **Tezspire start date**: _____
   a. Have the patient's signs and symptoms improved with Tezspire?
      ☐ Yes ☐ No, Comment: _____ ☐ Other:_____
5. 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 ☐ Attach Chart Notes	☐ Attach Diagnostic Tests
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**