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
Ultomiris™ (ravulizumab intravenous infusion) HCPCS CODE: J1303

Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

This form is to be used by participating physicians to obtain coverage for Ultomiris. 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. 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: _____
   Please provide the NPI number for the place of administration: _____
4. Will the patient receive the first loading dose under the guidance of a health care provider prior to subcutaneous self-administered formulation? ☐ Yes ☐ No Comment: _____

5. **Initiation AND Continuation of therapy:**
   a. Will the patient be receiving Ultomiris concurrently with Soliris, Empaveli, immunoglobin therapy (IVIG), or other medications to treat any of the diagnoses below?
      ☐ yes ☐ no Comment: _____
   b. Please check the patient's diagnosis:
      ☐ Paroxysmal nocturnal hemoglobinuria (PNH) ☐ Atypical hemolytic uremic syndrome (aHUS) ☐ Refractory generalized myasthenia gravis (gMG
      ☐ Other _____
   c. **For PNH**:
      i. Does the patient have flow cytometric confirmation of PNH type III red cells? ☐ Yes, Please provide laboratory report for review: _____, Date: _____ ☐ No
      ii. How many transfusions has the patient had in the previous 24 months (prior to Ultomiris)? _____
      iii. Has the patient experienced a major adverse thrombotic vascular event from thromboembolism?
      ☐ Yes, List event: _____ ☐ No Comment _____
      iv. What is the patient's lactic dehydrogenase (LDH) level? _____Units/L Lab range: _____ Date: _____
      v. Which of these symptoms does the patient experience? ☐ Weakness ☐ Fatigue ☐ Hemoglobinuria ☐ Abdominal pain ☐ Dyspnea ☐ Hemoglobin < 10 g/dL ☐ A major vascular event
      ☐ Dysphagia ☐ Erectile dysfunction ☐ Other _____
   d. **For aHUS:**
      i. Have common causes of typical hemolytic uremic syndrome been rule out, including infectious causes of HUS and thrombotic thrombocytopenic purpura (TTP)?
      ☐ Yes ☐ No Comment: _____
      ii. What is the hemoglobin level prior to initiation of treatment? _____g/dL Date: _____
      iii. What is the platelet count prior to initiation of treatment? _____/mm3 Date: _____
      iv. Does the patient have evidence of hemolysis? ☐ Yes ☐ No Comment: _____
         1. If yes, what is the patient's lactic dehydrogenase (LDH) level? _____Units/L Lab range: _____ Date: _____
         2. If yes, what is the patient's haptoglobin level? _____mg/dL Date: _____
         3. If yes, does the patient have schistocytosis? ☐ Yes ☐ No Comment: _____
      v. What is the patient serum creatinine? _____mg/dL Date: _____
      vi. Is the patient currently undergoing dialysis? ☐ Yes ☐ No Comment: _____
   e. **For refractory gMG:**
      i. How has the patient been diagnosed with gMG? (Please attach any tests confirming diagnosis) ☐ Anti-AChR antibody test ☐ Edrophonium test
      ☐ Clinical response to oral cholinesterase inhibitors (ex. pyridostigmine) ☐ Repetitive nerve stimulation (RNS) ☐ Single-fiber electromyography (SFEMG)
      ☐ Other:_____
      ii. Does the patient have a history of thymectomy within 12 months, current thymoma, or other neoplasms of the thymus?
      ☐ Yes, Date: _____ ☐ No
      iii. What is the severity of the patient's MG? ☐ Class I ☐ Class II ☐ Class III ☐ Class IV ☐ Class V
      iv. Has the patient tried and failed therapy with at least one conventional therapy?
      ☐ Methotrexate Date started: _____ Date ended: _____
      ☐ Azathioprine Date started: _____ Date ended: _____
      ☐ Cyclophosphamide Date started: _____ Date ended: _____
      ☐ Cyclosporine Date started: _____ Date ended: _____
      ☐ Mycophenolate mofetil Date started: _____ Date ended: _____
      ☐ Tacrolimus Date started: _____ Date ended: _____
      ☐ Other: _____, Date started: _____ Date ended: _____
      v. Has the patient tried and failed Vyvgart? ☐ Yes ☐ No Comment _____
      vi. Is the patient currently receiving and will continue to receive a standard of care regimen for their diagnosis with Ultomiris? ☐ Yes ☐ No Comment: _____

6. **Continuation request:** Ultomiris start date _____
   a. Has the patient's condition improved while on therapy with Ultomiris? ☐ Yes ☐ No Comment: _____

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	☐ 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**

1/31/2020; 3/17/2020; 12/3/2020; 6/10/2021; 6/9/2022; 10/5/2022