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
Casgevy™ (exagamglogene autotemcel)
HCPCS CODE: J3590

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This form is to be used by participating physicians to obtain coverage for Casgevy. 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	☐ Casgevy	**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 of therapy *Date when patient started therapy:* _____
2. Please provide the NPI number for the place of administration: _____
3. Please specify the location of administration (e.g. name of facility): _____

4. **Initiation AND Continuation of therapy:**
   a. What is the patient's diagnosis?
   ☐ Sickle cell disease (SCD) (***go to b***) ☐ β-thalassemia (***go to c***) ☐ Other – *please specify diagnosis:* _____

   b. **Sickle cell disease**
      i. Does the patient have a genetic test confirming sickle cell disease? ***(Please attach any tests confirming diagnosis)*** ☐ Yes ☐ No
      ii. How many vaso-occlusive crises has the patient experienced in the past 24 months? ☐ <4 ☐ ≤4
      iii. Has the patient tried and failed or has a contraindication or intolerance to hydroxyurea?
      ☐ Yes ☐ No, please explain: _____

   c. **β-thalassemia**
      i. Does the patient have a genetic test confirming β-thalassemia? ***(Please attach any tests confirming diagnosis)*** ☐ Yes ☐ No
      ii. Is the patient red blood cell transfusion dependent?
      ☐ No
      ☐ Yes, please select from the following:
      ☐ History of at least 100mL/kg/year of packed red bloods cells (pRBC) in the past 2 years
      ☐ Managed with standard thalassemia guidelines with ≥ 8 transfusions of pRBCs per year in the previous two years

   d. Does the patient have any of the following:
   ☐ Positive presence of HIV-1 or HIV-2, hepatitis B, or hepatitis C
   ☐ White blood cell count less than 3×10^9/L or platelet count less than 50×10^9/L not related hypersplenism
   ☐ History of cirrhosis, any evidence of bridging fibrosis, or active hepatitis
   ☐ A prior hematopoietic stem cell transplant (HSCT) or currently be eligible for a HSCT with an HLA matched family donor
   ☐ Prior or current malignancy or immunodeficiency disorder
   ☐ Advanced liver disease defined as alanine transferase greater than 3 times the upper limit of normal, total bilirubin greater than 2 times the upper limit of normal, or baseline prothrombin time 1.5 times the upper limit of normal
   ☐ Uncorrected bleeding disorder
   ☐ Other: _____ ☐ None of the above

   e. Has the patient received or being considered for any other gene therapy treatments?
   ☐ Yes, please explain: _____ ☐ No

5. **Continuation of therapy** - *Please include rationale for continuation of therapy*_____

6. *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 necessary chart notes	☐ Important laboratory results
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**