

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
Evenity™ (romosozumab-aqqg for subcutaneous injection)
HCPCS CODE: J3111



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This form is to be used by participating physicians to obtain coverage for Evenity™. 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. <input type="checkbox"/> Male <input type="checkbox"/> 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

- Initiation or Continuation of treatment? ☐ Initiation ☐ Continuation *Date patient started therapy:* _____
- Site of administration? ☐ Provider office/Home infusion ☐ Other: _____
☐ Hospital outpatient facility (go to #3) *Reason for Hospital Outpatient administration:* _____
- Please specify location of administration if hospital outpatient infusion:** _____
- Please provide the NPI number for the place of administration:** _____
- Initiation:**
 - Primary Indication: ☐ Postmenopausal women with Osteoporosis ☐ Osteopenia ☐ History of fragility fracture ☐ Other: _____
 - Please complete the chart below with the patient's T-scores:

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

- Check the bisphosphonate(s) the patient received and dates of therapy:

Bisphosphonates	Dates of therapy	Outcome / Reason for D/C
<input type="checkbox"/> None, explain: _____		<input type="checkbox"/> Contraindicated, Explain: _____
<input type="checkbox"/> Reclast/Zometa (zoledronic acid)	<i>Start:</i> _____ <i>End:</i> _____	<input type="checkbox"/> Not tolerated <input type="checkbox"/> Failure Explain: _____
<input type="checkbox"/> Aredia (pamidronate)	<i>Start:</i> _____ <i>End:</i> _____	<input type="checkbox"/> Not tolerated <input type="checkbox"/> Failure Explain: _____
<input type="checkbox"/> Boniva (ibandronate) <input type="checkbox"/> IV <input type="checkbox"/> PO	<i>Start:</i> _____ <i>End:</i> _____	<input type="checkbox"/> Not tolerated <input type="checkbox"/> Failure Explain: _____
<input type="checkbox"/> Fosamax (alendronate)	<i>Start:</i> _____ <i>End:</i> _____	<input type="checkbox"/> Not tolerated <input type="checkbox"/> Failure Explain: _____
<input type="checkbox"/> Actonel (risedronate)	<i>Start:</i> _____ <i>End:</i> _____	<input type="checkbox"/> Not tolerated <input type="checkbox"/> Failure Explain: _____
<input type="checkbox"/> Other _____	<i>Start:</i> _____ <i>End:</i> _____	<input type="checkbox"/> Not tolerated <input type="checkbox"/> Failure Explain: _____

- Please provide response to bisphosphonate therapy (select the most appropriate response): ☐ BMD/T-score improved ☐ BMD/T-score remained the same
☐ BMD/T-score declined ☐ Patient had fracture during a fall from standing height (osteoporosis related fracture)
☐ Patient had non-traumatic fractures to major bones ☐ Other, Please list duration of treatment and describe response to bisphosphonates: _____
 - Which of the following has the patient experienced that would prevent the patient from using a bisphosphonate?
☐ Creatinine clearance less than 30 ml/min, What is the **Creatine Clearance:** _____ ml/min
☐ Documented hypersensitivity to the medication ☐ Documented history of jaw necrosis while using bisphosphonate
☐ Bone pain while using bisphosphonate ☐ Flu-like symptoms while using bisphosphonate
☐ Other; Please list the contraindication or side effects to bisphosphonate therapy: _____
 - Will the patient be using Evenity in combination with bisphosphonates (for example: Fosamax or Reclast), Forteo, Tymlos, or Prolia? ☐ Yes ☐ No
- Continuation of therapy - Please include rationale for continuation of therapy** _____
 - 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	<input type="checkbox"/> Form Completely Filled Out <input type="checkbox"/> Attached Chart Notes <input type="checkbox"/> BMD (prior to and after Evenity)	<input type="checkbox"/> Prior Trials (bisphosphonates) <input type="checkbox"/> Concurrent medical problems <input type="checkbox"/> 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

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