

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.



This form is to be used by participating physicians to obtain coverage for Eylea and Eylea HD. 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.

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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

- Is this request for: Initiation Continuation *Date patient started therapy:* _____
- Please provide the NPI number for the place of administration: _____
- Initiation AND Continuation of therapy:**
 - What eye(s) will be treated? Left eye Right eye
 - What is the patient's dose and frequency of requested medication?
Initiation - Dose: _____ mg Frequency: 4 weeks 6 weeks 8 weeks Other: _____
Maintenance - Dose: _____ mg Frequency every: 4 weeks 6 weeks 8 weeks Other: _____
 - What is the patient's diagnosis?
 Neovascular (wet) age-related macular degeneration (AMD) Diabetic retinopathy (DR) Retinopathy of Prematurity (ROP- go to f)
 Macular edema due to retinal vein occlusion (RVO) Other, Please specify: _____
 Diabetic macular edema (DME)
 - What is the visual acuity in the right eye? _____
 - What is the visual acuity in the left eye? _____
 - Has the patient tried Avastin or bevacizumab biosimilar intravitreal treatment?
 No
 Yes
 - Which eye was treated? Left eye Right eye
 - Please enter number of Avastin or a bevacizumab biosimilar injections patient has received and in which eye? _____
 - What was the patient's frequency of Avastin or bevacizumab biosimilar? 4 weeks 6 weeks 8 weeks Other: _____
 - Date of the last three Avastin or a bevacizumab biosimilar injection: _____
 - What was the patient's outcome while on Avastin or bevacizumab biosimilar therapy?
 Visual acuity improvement Reduction in edema Decrease in retinal thickness Condition remained the same
 Worsening in visual acuity Increased edema Increase in retinal thickness Persistent edema
 Intolerance to the medication: _____
 Other, Please list: _____
 - Has the patient failed treatment with other anti-VEGF therapy? Yes No
 - If yes, List what treatment(s) patient failed: _____
 - Diagnosis of retinopathy of prematurity (ROP) only
 - What is the patient's gestational age (weeks)? _____
 - What is the patient's birth weight (kg)? _____
 - What is the patient's current weight(kg)? _____
 - What is the patient's ROP classified as?
 ROP Zone I Stage 1+, 2+, 3 or 3+ ROP Zone II Stage 2+ or 3+
 Aggressive posterior ROP Other
- Continuation of therapy:**
 - How has the patient's condition changed while on therapy?
 Improved; Please describe: _____
 Stable; Please describe: _____
 Worsened; Please describe: _____
 Other; Please describe: _____

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"/> Pertinent test 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