

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](http://bcbsm.com) for details. Then:

1. Log in to [availity.com](http://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**  
**Lyfgenia™ (lovotibeglogene autotemce)**  
**HCPCS CODE: J3590**



This form is to be used by participating physicians to obtain coverage for Lyfgenia. 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
<b>Name</b>	<b>Name</b>
<b>ID Number</b>	<b>Specialty</b>
<b>D.O.B.</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>Address</b>
<b>Diagnosis</b>	<b>City /State/Zip</b>
<b>Drug Name</b> <input type="checkbox"/> Lyfgenia	<b>Phone/Fax: P:</b> (    ) - <b>F:</b> (    ) -
<b>Dose and Quantity</b>	<b>NPI</b>
<b>Directions</b>	<b>Contact Person</b>
<b>Date of Service(s)</b>	<b>Contact Person Phone / Ext.</b>

**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)
    - β-thalassemia
    - Other – *please specify diagnosis:* \_\_\_\_\_
  - b. Does the patient have a genetic test confirming sickle cell disease? **(Please attach any tests confirming diagnosis)**
    - Yes  No
  - c. How many vaso-occlusive crises has the patient experienced in the past 24 months?  <4  ≤4
  - d. Has the patient tried and failed or has a contraindication or intolerance to hydroxyurea?
    - Yes  No, please explain: \_\_\_\_\_
  - e. Has the patient received or being considered for any other gene therapy treatments?
    - Yes, please explain: \_\_\_\_\_  No
  - f. Does the patient have any of the following:
    - Positive presence of HIV-1 or HIV-2, hepatitis B, or hepatitis C
    - Inadequate bone marrow function, as defined by an absolute neutrophil count of less than 1000/μL or less than 500/μL for patient taking hydroxyurea or a platelet count less than 120,000/μL without hypersplenism
    - Prior treatment with an allogenic stem cell transplant
    - 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
    - Other: \_\_\_\_\_
    - None of the above
  - g. Has the patient received prior or being considered to receive gene therapy treatments for sickle cell disease?
    - Yes, please explain: \_\_\_\_\_  No
5. Has the patient has experienced an intolerance, contraindication, or adverse event for the requested indication to Casgevy? Please provide date and type of intolerance patient has had.  Yes, please explain: \_\_\_\_\_  No
6. **Continuation of therapy - Please include rationale for continuation of therapy** \_\_\_\_\_
7. *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

<b>Physician's Name</b>	<b>Physician Signature</b>	<b>Date</b>	
<b>Step 2: Checklist</b>	<input type="checkbox"/> Form Completely Filled Out <input type="checkbox"/> Attached necessary chart notes		<input type="checkbox"/> Important laboratory results
<b>Step 3: Submit</b>	<b>By Fax: BCBSM Specialty Pharmacy Mailbox</b> 1-877-325-5979	<b>By Mail: BCBSM Specialty Pharmacy Program</b> P.O. Box 312320, Detroit, MI 48231-2320	

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