

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
Omvoh™ (mirikizumab-mrkz)
HCPCS CODE: J3590



This form is to be used by participating physicians to obtain coverage for Omvoh. 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
Pt weight (in kg) Date recorded: _____	City /State/Zip
Diagnosis	Phone/Fax: P: () - F: () -
Drug Name <input type="checkbox"/>	NPI
Dose and Quantity	Contact Person
Directions	Contact Person Phone / Ext.
Date of Service(s)	

STEP 1: DISEASE STATE INFORMATION

1. Is this request for initiation or renewal of therapy? Initiation Continuation **Date patient started therapy:** _____
2. How is this medication being administered? Self-administered **(Please fax this completed form to BCBSM at (866) 601-4425)**
 Health Care Professional administered **(Continue to #3)**
3. Site of administration? Provider office/Home infusion Other: _____
 Hospital outpatient facility (go to #4) **Reason for Hospital Outpatient administration:** _____
4. **Please specify location of administration if hospital outpatient infusion:** _____
5. **Please provide the NPI number for the place of administration:** _____
6. **Initiation of therapy:**
 - a. Please check the patient's diagnosis: Ulcerative colitis (UC) Other: _____
 - b. Has the patient tried and failed therapy with at least one conventional therapy?
 - Systemic corticosteroid daily for 7 days: P list name of drug(s): _____ Date started: _____ Date ended: _____
 - Sulfasalazine, Date started: _____ Date ended: _____
 - Mercaptopurine, Date started: _____ Date ended: _____
 - Azathioprine, Date started: _____ Date ended: _____
 - Methotrexate, Date started: _____ Date ended: _____
 - Other: _____, Date started: _____ Date ended: _____
 - c. Will the patient be receiving Omvoh with other biologic agents (for example: Remicade, Humira, Kineret, Entyvio, Tremfya, etc.) or with targeted DMARD medications (for example: Otezla)? Yes, Please provide rationale: _____ No
7. **Continuation request:** Omvoh start date: _____
 - a. Have the patient's signs and symptoms improved with Omvoh?
 - 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	<input type="checkbox"/> Form Completely Filled Out <input type="checkbox"/> Attached Chart Notes	<input type="checkbox"/> Weight (specify lb or kg) , BSA
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

Confidentiality notice: This transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reliance on the contents of this document is strictly prohibited. If you have received this in error, please notify the sender to arrange for the return of this document.