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.

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Blue Cross Blue Shield/Blue Care Network of Michigan
Medication Authorization Request Form
Ranibizumab

Lucentis® (ranibizumab): J2778, Susvimo™ (ranibizumab): J2779, Byooviz® (Ranibizumab-nuna): Q5124, Cimerli™ (ranibizumab-eqrn): Q5128

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This form is to be used by participating physicians to obtain coverage for Lucentis, Byooviz, Susvimo, or Cimerli. 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		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 *Date patient started therapy:* ________________
2. Please provide the NPI number for the place of administration: ____________________________________
3. **Initiation AND Continuation of therapy:**
   a. What eye(s) will be treated? ☐ Left eye ☐ Right eye
   b. 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: ______________
   c. What is the patient's diagnosis?
      ☐ Neovascular (wet) age-related macular degeneration (AMD) ☐ Diabetic retinopathy (DR)
      ☐ Myopic choroidal neovascularization (mCNV)
      ☐ Macular edema due to retinal vein occlusion (RVO) ☐ Other, Please specify: ______________________
      ☐ Diabetic macular edema (DME)
         a. What is the visual acuity in the right eye? ______________
         b. What is the visual acuity in the left eye? _______________
   d. Has the patient tried Avastin or bevacizumab biosimilar intravitreal treatment?
      ☐ No
      ☐ Yes
         i. Which eye was treated? ☐ Left eye ☐ Right eye
         ii. Please enter number of Avastin or a bevacizumab biosimilar injections patient has received and in which eye? _____________
         iii. What was the patient's frequency of Avastin or bevacizumab biosimilar? ☐ 4 weeks ☐ 6 weeks ☐ 8 weeks ☐ Other: ___________
         iv. Date of the last Avastin or a bevacizumab biosimilar injection: _________________
         v. 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
            ☐ Intolerance to the medication: __________________________
            ☐ Other, Please list: ______________________
   e. Has the patient failed treatment with other anti–VEGF therapy? ☐ Yes ☐ No
         i. If yes, List what treatment(s) patient failed: ____
   f. **Susvimo only**:
         i. Has the patient experienced disease stability or improvement following at least 2 injections in the same eye of either Beovu, Eylea, or Lucentis prior to Susvimo therapy? ☐ Yes ☐ No, please explain: ________________
         ii. Is supplemental treatment needed with Lucentis while on Susvimo?
            ☐ No
            ☐ Yes
               1. Did the patient experience decrease in visual acuity by half from the baseline visual acuity?
                  ☐ Yes ☐ No, please explain: ________________
               2. Did the patient experience an of increase of 150 µm or more in retinal thickness?
                  ☐ Yes ☐ No, please explain: ________________
4. **Continuation of therapy:**
   a. 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	☐ Form Completely Filled Out ☐ Attached chart notes	☐ 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**

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