

## Submit medical drug prior authorization requests online

As part of our efforts to make the prior authorization (PA) process more efficient, we're encouraging prescribers register and use our Web-based system when prescribing medical drugs for commercial members. This new application gives providers the ability to submit forms electronically and the ability to lookup the status of their medical drug PA request.

### In-state Providers

**In order to be able to submit your prior authorization requests electronically, you will need to:**

- Become a registered web-DENIS user
- Complete the addendum P form located under the Provider Secured Services link on **bcbsm.com** (Link listed below)
  - <http://www.bcbsm.com/providers/help/faqs/medical-drug-prior-authorization.html>

**To request a drug prior authorization, please go to bcbsm.com and follow these easy steps:**

#### **Log into the Provider Portal**

- Navigate to bcbsm.com, and enter your provided username and password in the Provider Secured Services box

#### **Navigate to the Medication Prior Authorization Link**

- Select the quick link on the left side of the webpage labeled "Medical Benefit-Medication Prior Authorization" or scroll down the center of the page to find a duplicate link

#### **Enter your National Provider Identifier (NPI)**

- Type in or select your NPI from the drop down list. Once you complete this step, you will be routed to Novologix

#### **Complete the Prior Authorization Request**

- Refer to BCBSM Prior Authorization Guide for instructions (accessible from the help menu under Blue Cross Blue Shield of Michigan).

### Out-of-State Providers

**In order to be able to submit your prior authorization requests electronically, you will need to:**

- Access the Electronic Provider Access (EPA) via local Blues Plan
  - Download the Registration form for electronic access from the Medical Prior Authorization Review link
- AND**
- Submit the Registration form with a completed Medication Authorization Request Form (MARF) via fax or mail
  - For additional information or instructions, please refer to the e-Learning Training Modules in the Provider Secure Services page OR contact the Help Desk at 877-258-3932

**Blue Cross Blue Shield/Blue Care Network of Michigan**  
**Medication Authorization Request Form**  
**Ultomiris™ (ravulizumab intravenous infusion) HCPCS CODE: C9052, J1303**



This form is to be used by participating physicians to obtain coverage for Ultomiris. 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
<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>	<b>Phone/Fax: P: (     ) -     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 **Date patient started therapy:** \_\_\_\_\_
2. What is the patient's dose and frequency of requested therapy? \_\_\_\_\_
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. **Initiation AND Continuation of therapy:**
  - a. Please check the patient's diagnosis:
    - i.  Paroxysmal nocturnal hemoglobinuria (PNH, flow cytometric confirmation of at least 10% PNH type III red cells)
    - ii.  Other \_\_\_\_\_
  - b. Has the patient been vaccinated against meningococcal infection at least 2 weeks prior to Ultomiris treatment?  
 yes: Date \_\_\_\_\_  no Comment \_\_\_\_\_
  - c. What was the platelet count prior to initiation of treatment? \_\_\_\_\_/mcl Date: \_\_\_\_\_
  - d. How many transfusions has the patient had in the previous 24 months (prior to Ultomiris)? \_\_\_\_\_
  - e. Has the patient experienced a major adverse thrombotic vascular event from thromboembolism?  
 yes, List event: \_\_\_\_\_  no Comment \_\_\_\_\_
  - f. What is the patient lactic dehydrogenase (LDH) level? \_\_\_\_\_ Units/L Date: \_\_\_\_\_
  - g. Which of these symptoms does the patient experience?
    - i.  Weakness
    - ii.  Fatigue
    - iii.  Hemoglobinuria
    - iv.  Abdominal pain
    - v.  Dyspnea
    - vi.  Hemoglobin < 10 g/dL
    - vii.  A major vascular event
    - viii.  Dysphagia
    - ix.  Erectile dysfunction
6. **Continuation request:** Ultomiris start date \_\_\_\_\_
  - a. Please describe the clinical response to Ultomiris treatment: (check all that apply)
    - i.  Provide the LDH levels after treatment: \_\_\_\_\_
    - ii.  Decreased need for transfusions
    - iii.  Decreased thromboembolic events
    - iv.  Other: \_\_\_\_\_
    - v.  None

**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>
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<b>Step 2:</b> Checklist	<input type="checkbox"/> Form Completely Filled Out <input type="checkbox"/> Attached Chart Notes	<input type="checkbox"/> Concurrent Medical Problems <input type="checkbox"/> Prior Therapies
<b>Step 3:</b> Submit	<b>By Fax: BCBSM Specialty Pharmacy Mailbox 1-877-325-5979</b>	<b>By Mail: BCBSM Specialty Pharmacy Program P.O. Box 312320, Detroit, MI 48231-2320</b>

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