Blue Cross Blue Shield of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

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

Disclaimer: Access is only available to registered users. A valid individual NPI is required for registration.

Blue Cross Blue Shield/Blue Care Network of Michigan Medication Authorization Request Form
Brand Zolgensma® (onasemnogene abeparvovec-xioi)
HCPCS CODE : J3490, J3590, C9399

Blue Cross Blue Shield Blue Care Network of Michigan

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This form is to be used by participating physicians to obtain coverage for Zolgensma. 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	☐ Zolgensma	**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 specify the location of administration (e.g. name of facility):
   _____
3. **Initiation AND Continuation of therapy:**
   a. What is the member's age?: _____
   b. What is the member's diagnosis?
      i. ☐ Spinal Muscular Atrophy *(go to c)*
      ii. ☐ Other – *please specify diagnosis:* _____ *(go to*
   c. Does the member have a genetically-confirmed double-deletion of SMN1 exon 7 and less than or equal to three copies of the SMN2 gene?
      ☐ Yes ☐ No ☐ Unknown
   d. Does the member have antibodies against the viral vector, AAV9?
      ☐ Yes ☐ No ☐ Unknown
   e. Will the member be receiving daily corticosteroids starting at least 24 hours prior to therapy and continuing 30 days after Zolgensma is given?
      ☐ Yes ☐ No ☐ Unknown
   f. Please check all that apply relating to this patient's treatment history:
      ☐ Has previously received Spinraza ☐ Has NEVER received Spinraza ☐ Will be receiving Spinraza with Zolgensma
      ☐ Will NOT be receiving Spinraza will Zolgensma
4. **Continuation of therapy -** *Please include rationale for continuation of therapy*_____

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 necessary chart notes	☐ Important laboratory 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**