

## 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 Availity user by clicking the following hyperlink, [avility.com/bcbsm](https://avility.com/bcbsm), and following the steps.

**To request a drug prior authorization, please go to [bcbsm.com](https://bcbsm.com) and follow these easy steps:**

#### Log into the Availity

- Navigate to [avility.com](https://avility.com), and enter your provided username and password
- Click the Payer Spaces drop down and select BCBSM BCN icon
- Scroll down the page and select the appropriate Novologix link for your member

#### Complete the Prior Authorization Request

- To login to Novologix, enter your User ID and Password
- Click the Authorizations drop down and select Create Authorization
- Enter in the members specific details and select the correct member on contract
- Complete the required fields and select the correct drug product in the Authorization Lines section
- Click Submit and complete the question to request prior authorization

### 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.

**Authorization Request Form  
Amvuttra™ (vutrisiran) HCPCS CODE: J0225**



Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

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

**STEP 1: DISEASE STATE INFORMATION**

- Is this request for:  Initiation  Continuation *Date patient started therapy:* \_\_\_\_\_
- Please provide the NPI number for the place of administration: \_\_\_\_\_
- Initiation AND Continuation of therapy:**
  - Does the patient have peripheral neuropathy caused by hereditary transthyretin amyloidosis (hATTR) with a documented TTR mutation?  Yes  No *Comment* \_\_\_\_\_
  - Please check off the symptoms of neuropathy the patient is experiencing:  Tingling/pain in the hands/feet/arms  
 Numbness/tingling in the wrists  Carpal tunnel syndrome  Loss of ability to sense temperature  
 Weakness in legs/difficulty walking  Difficulty with fine motor skills  Orthostasis  Abnormal sweating  
 Constipation/diarrhea  Nausea/vomiting  Anorexia/early satiety  Loss of feeling in the hand and/or feet  
 Other: \_\_\_\_\_
  - Does the patient have any signs or symptoms of ocular amyloidosis or primary/leptomeningeal amyloidosis?  Yes  No
    - If Yes, do these predominate over polyneuropathy symptomology?  
 Yes  No *Comment* \_\_\_\_\_
  - What is the patient's PND score before starting Amvuttra?  0  I  II  IIIA  IIIB  IV
  - What is the patient's FAP stage before starting Amvuttra?  0  1  2  3
  - Will the patient be using Amvuttra in combination with other therapies approved for transthyretin-mediated amyloidosis?  
 Yes  No *Comment* \_\_\_\_\_
  - Has the patient had a prior liver transplant?  Yes  No
  - Does the patient have heart failure?  Yes  No *If Yes: New York Heart Association Class*  I  II  III  IV
- Continuation of therapy:**
  - Has the patient's condition improved while on therapy with Amvuttra?  
 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
<b>Step 2:</b> Checklist	<input type="checkbox"/> Form Completely Filled Out <input type="checkbox"/> Attached Chart Notes	
<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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