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

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
Cinqair® (reslizumab) HCPCS CODE: J2786

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 Cinqair®. 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. Site of administration? ☐ Provider office/Home infusion ☐ Other: _____
   ☐ Hospital outpatient facility (go to #3) *Reason for Hospital Outpatient administration:* _____

3. Please specify location of administration if hospital outpatient infusion: _____

4. Please provide the NPI number for the place of administration: _____

5. **Initiation AND Continuation of therapy:**
   a. Please check the patient's diagnosis: ☐ Severe uncontrolled eosinophilic asthma ☐ Other: _____
   b. What is the patient's blood eosinophil level at initiation of therapy, in cells/microliter?
      ☐ Blood eosinophils level: _____ Date: _____
   c. Which treatment(s) did not adequately control the patient's severe eosinophilic asthma symptoms after a trial of at least 3 months?
      ☐ Systemic corticosteroid: _____ Date: *Start:* _____ *End:* _____
      ☐ High dose inhaled corticosteroids: _____ Date: *Start:* _____ *End:* _____
      ☐ Long acting beta2-agonist: _____ Date: *Start:* _____ *End:* _____
      ☐ Leukotriene receptor antagonist: _____ Date: *Start:* _____ *End:* _____
      ☐ Combination asthma inhaler with a HIGH dose corticosteroid and a long acting beta agonist: _____ Date: *Start:* _____ *End:* _____
      ☐ Combination asthma inhaler with a MEDIUM dose corticosteroid and a long acting beta agonist: _____ Date: *Start:* _____ *End:* _____
      ☐ Long acting muscarinic antagonist (LAMA): _____ Date: *Start:* _____ *End:* _____
      ☐ Other: _____ Date: *Start:* _____ *End:* _____
   d. Is the patient currently receiving and will continue to receive a standard of care regimen for their diagnosis with Cinqair?
      ☐ Yes ☐ No Comment: _____
   e. Will the patient be using Cinqair in combination with other biologic agents (for example: Xolair®, Nucala® or Fasenra™)?
      ☐ Yes ☐ No Comment: _____

6. **Continuation request:** (please answer above questions as well): **Cinqair start date**: _____
   a. Have the patient's signs and symptoms improved with Cinqair?
      ☐ Yes

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 ☐ Attach Chart Notes	☐ Attach Diagnostic Tests
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**

11/6/2015; 2/25/2016, 6/2/2016; 2/2/2018;10/11/2018; 3/17/2020; 10/7/201