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 Availity user by clicking the following hyperlink, **availity.com/bcbsm**, and following the steps.

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

**Log into the Availity**

- Navigate to **availity.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.

**Blue Cross Blue Shield/Blue Care Network of Michigan**
**Medication Authorization Request Form**
**Crysvita® (burosumab-twza) HCPCS CODE: J0584**

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This form is to be used by participating physicians to obtain coverage for Crysvita. 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 |
| Pt weight (in kg) | Date recorded:__________ | |
| 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 or renewal of therapy? ☐ 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:
      ☐ X-linked hypophosphatemia (XLH)
      ☐ Treatment of FGF23-related hypophosphatemia in tumor induced osteomalacia (TIO)
      ☐ Other: ______________________
   b. XLH:
      i. Genetic testing to confirm diagnosis: _________________________________ ***(Please attach any tests confirming diagnosis)***
      ii. Please provide serum fibroblast growth factor 23 (FGF23) level: ______________________ Date: ____________
      iii. Please provide the serum Phosphorus level in mg/dL: ______________________ Date: ____________
      iv. Please provide the measurable bone/joint pain (BPI-Q3 score): ______________________ Date: ____________
      v. What is the patient clinical signs and symptoms of the disease? ☐ Rickets ☐ Growth retardation ☐ Musculoskeletal pain ☐ Bone fractures ☐ Other: _________________
   c. Is the FGF23-related hypophosphatemia in TIO associated with phosphaturic mesenchymal tumors that cannot be resected or localized?
      ☐ Yes ☐ No Comment: _________________________
      i. Please provide serum fibroblast growth factor 23 (FGF23) level: ______________________ Date: ____________
      ii. Please provide the serum phosphorus level in mg/dL: ______________________ Date: ____________
      iii. Please provide the ratio of renal tubular maximum reabsorption rate of phosphate to glomerular filtration rate (TmP/GFR): ______________________ Date: ____________ Normal reference range: __________________________
      iv. What is the patient clinical signs and symptoms of the disease? ☐ Bone pain ☐ Fractures ☐ Difficulty walking ☐ Muscle weakness ☐ Fatigue ☐ Other: _________________
   d. Please select which drugs has the patient tried and failed for the requested indication: ______________________
      ☐ Vitamin D ☐ Phosphate supplements ☐ Other: _________________
6. **Continuation request:** Crysvita start date: _____________________
   a. Has the patient had documented beneficial clinical response to Crysvita?
      ☐ Yes ☐ No Comment: _________________________
   b. How has the patient improved on therapy? ☐ Normalization of serum phosphate ☐ Enhanced height velocity ☐ Improvement in skeletal deformities ☐ Reduction of fractures ☐ Reduction of generalized bone pain ☐ Other: ___________________ ☐ None
7. *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<br>☐ Attached Chart Notes | ☐ Serum Pi level |
| **Step 3:** Submit | **By Fax: BCBSM Specialty Pharmacy Mailbox**<br>**1-877-325-5979** | **By Mail: BCBSM Specialty Pharmacy Program**<br>**P.O. Box 312320, Detroit, MI 48231-2320** |

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