

## 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](https://www.availity.com/bcbsm), and following the steps.

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

#### Log into the Availity

- Navigate to [availity.com](https://www.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**



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**Aldurazyme® (aronidase) J1931, Elaprased® (idursulfase) J1743, Mepsevii™ (vestronidase alfa-vjkb) J3397, Naglazyme® (galsulfase) J1458, Vimizim® (elosulfase alfa) J1322**

This form is to be used by participating physicians to obtain coverage for ALDURAZYME®, ELAPRASE®, MEPSEVII™, NAGLAZYME®, and VIMIZIM®. 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 of therapy *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. What is the patient's diagnosis?  
 Mucopolysaccharidosis (MPS) I (Hurler Syndrome/Hurler-Scheie/Scheie forms)  MPS II (Hunter's syndrome)  
 MPS IVA (Morquio A syndrome)  MPS VI (Maroteaux-Lamy syndrome)  
 Mucopolysaccharidosis VII (MPS VII, Sly syndrome)  
 Other, list diagnosis \_\_\_\_\_
  - b. **Aldurazyme:** How has the patient been diagnosed with MPS I? *(Please attach any tests confirming diagnosis)*  
 Decrease in alpha-L- iduronidase activity  
 Genetic testing showing a mutation in the IDUA gene  
 Other: \_\_\_\_\_
  - c. **Elaprased:** How has the patient been diagnosed with MPS II? *(Please attach any tests confirming diagnosis)*  
 Decrease in iduronate sulfatase activity  
 Genetic testing showing a mutation in the IDS gene  
 Other: \_\_\_\_\_
  - d. **Mepsevii:** How has the patient been diagnosed with MPS VII? *(Please attach any tests confirming diagnosis)*  
 Decrease in Beta-glucuronidase activity  
 Genetic testing showing a mutation in the GUSB gene  
 Other: \_\_\_\_\_
  - e. **Naglazyme:** How has the patient been diagnosed with MPS VI? *(Please attach any tests confirming diagnosis)*  
 Decrease in N-acetylgalactosamine-4-sulfatase activity  
 Genetic testing showing a mutation in the ARSB gene  
 Other: \_\_\_\_\_
  - f. **Vimizim:** How has the patient been diagnosed with MPS IVA? *(Please attach any tests confirming diagnosis)*  
 Decrease in N-acetyl-galactosamine-6-sulfatase activity  
 Genetic testing showing a mutation in the GALNS gene  
 Other: \_\_\_\_\_
6. **Continuation of therapy:**
  - a. If the patient is continuing therapy, please give the patient's current disease status since beginning treatment:  
 Improved; Please describe: \_\_\_\_\_  
 Stable; Please describe: \_\_\_\_\_  
 Worsened; Please describe: \_\_\_\_\_  
 Other; Please describe: \_\_\_\_\_

**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 \_\_\_\_\_

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

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