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

Eylea® (aflibercept): J0178, Lucentis® (ranibizumab): J2778, Susvimo™ (ranibizumab): J2779, Beovu® (brolucizumab-dbll): J0179, Macugen® (pegaptanib): J2503, Vabysmo™ (faricimab-svoa): J2777, Byooviz® (Ranibizumab-nuna): Q5124, Cimerli™ (ranibizumab-eqrn): J3490/J3590

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This form is to be used by participating physicians to obtain coverage for Eylea, Lucentis, Macugen, Beovu, Byooviz, Susvimo, Vabysmo, or Cimerli. 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. Please provide the NPI number for the place of administration: _____
3. **Initiation AND Continuation of therapy:**
   a. What eye(s) will be treated? ☐ Left eye ☐ Right eye
   b. What is the patient's dose and frequency of requested medication?
      Initiation - Dose: _____mg Frequency: ☐ 4 weeks ☐ 6 weeks ☐ 8 weeks ☐ Other: _____
      Maintenance - Dose: _____mg Frequency every: ☐ 4 weeks ☐ 6 weeks ☐ 8 weeks ☐ Other: _____
   c. What is the patient's diagnosis?
      ☐ Neovascular (wet) age-related macular degeneration (AMD) ☐ Diabetic retinopathy (DR)
      ☐ Myopic choroidal neovascularization (mCNV)
      ☐ Macular edema due to retinal vein occlusion (RVO) ☐ Other, Please specify: _____
      ☐ Diabetic macular edema (DME)
      i. **Only for Eylea for DME**:
         a. What is the visual acuity in the right eye? _____
         b. What is the visual acuity in the left eye? _____
   d. Has the patient tried Avastin or bevacizumab biosimilar intravitreal treatment?
      ☐ No
      ☐ Yes
      i. Which eye was treated? ☐ Left eye ☐ Right eye
      ii. Please enter number of Avastin or a bevacizumab biosimilar injections patient has received and in which eye? _____
      iii. What was the patient's frequency of Avastin or bevacizumab biosimilar? ☐ 4 weeks ☐ 6 weeks ☐ 8 weeks ☐ Other: _____
      iv. Date of the last Avastin or a bevacizumab biosimilar injection: _____
      v. What was the patient's outcome while on Avastin or bevacizumab biosimilar therapy?
      ☐ Visual acuity improvement ☐ Reduction in edema ☐ Decrease in retinal thickness ☐ Condition remained the same
      ☐ Worsening in visual acuity ☐ Increased edema ☐ Increase in retinal thickness
      ☐ Intolerance to the medication: _____
      ☐ Other, Please list: _____
   e. Has the patient failed treatment with other anti–VEGF therapy? ☐ Yes ☐ No
      i. If yes, List what treatment(s) patient failed: _____
   f. **Susvimo only**:
      i. Has the patient experienced disease stability or improvement following at least 2 injections in the same eye of either Beovu, Eylea, or Lucentis prior to Susvimo therapy? ☐ Yes ☐ No, please explain: _____
      ii. Is supplemental treatment needed with Lucentis while on Susvimo?
      ☐ No
      ☐ Yes
      1. Did the patient experience decrease in visual acuity by half from the baseline visual acuity?
      ☐ Yes ☐ No, please explain: _____
      2. Did the patient experience increase of 150 µm or more in retinal thickness?
      ☐ Yes ☐ No, please explain: _____
4. **Continuation of therapy:**
   a. How has the patient's condition changed while on therapy?
      ☐ Improved; Please describe: _____
      ☐ Stable; Please describe: _____
      ☐ Worsened; Please describe: _____
      ☐ Other; Please describe: _____

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 chart notes	☐ Pertinent test 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**

4/16/2018;10/11/2018; 11/4/2019; 12/9/2021; 2/24/2022; 10/7/2022