

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, 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 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.

Blue Cross Blue Shield/Blue Care Network of Michigan
Medication Authorization Request Form
Fasenra™ (benralizumab) HCPCS CODE: J0517



This form is to be used by participating physicians to obtain coverage for Fasenra™. 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 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	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. How is this medication being administered? Self-administered **(Please fax this completed form to BCBSM at (866) 601-4425)**
 Health Care Professional administered **(Continue to #3)**
3. Please provide reason(s) why the patient needs to receive Fasenra administered by a healthcare professional:
 Patients or caregivers who are unable to perform subcutaneous injections with proper technique
 Patient requires monthly medical support from the physician
 Other: _____
4. Site of administration? Provider office/Home infusion Other: _____
 Hospital outpatient facility (go to #4) **Reason for Hospital Outpatient administration:** _____
5. Please specify location of administration if hospital outpatient infusion: _____
6. Please provide the NPI number for the place of administration: _____
7. **Initiation AND Continuation of therapy:**
 - a. Please check the patient's diagnosis: Severe eosinophilic asthma Other: _____
 - b. What is the patient's blood eosinophil level at the initiation of therapy, in cells/microliter? _____ cells/microliter 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 inhaled beta agonist: _____ Date: Start: _____ End: _____
 Combination asthma inhaler with a MEDIUM dose corticosteroid and a long acting inhaled beta agonist: _____ Date: Start: _____ End: _____
 Long acting muscarinic antagonist (LAMA): _____ Date: Start: _____ End: _____
 Other: _____
 - d. Is the patient currently receiving and will continue to receive a standard of care regimen for their diagnosis with Fasenra?
 Yes No **Comment:** _____
 - e. Will the patient be using Fasenra in combination with other biologic medications for asthma (for example: Xolair, Nucala, Cinqair or Duxipent)?
 Yes No **Comment:** _____
8. **Continuation request:** (please answer above questions as well): **Fasenra start date:** _____
 - a. Have the patient's signs and symptoms improved with Fasenra?
 Yes No, **Comment:** _____ Other: _____

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 <input type="checkbox"/> Form Completely Filled Out <input type="checkbox"/> Attach Chart Notes	<input type="checkbox"/> 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

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