Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

How to submit prior authorization requests for medical benefit drugs

For Blue Cross commercial and BCN commercial

Revised May 2025

Follow these steps to submit prior authorization requests when prescribing most drugs covered under the medical benefit for Blue Cross Blue Shield of Michigan and Blue Care Network commercial members.

Note: The information below doesn't apply to oncology medical benefit drugs.

Michigan prescribers

To submit prior authorization requests electronically:

1. Log in to our provider portal (availity.com*).
2. Click *Payer Spaces* on the menu bar and click the BCBSM and BCN logo.
3. Click the *Medical/Pharm Drug Benefit Prior Auth (Commercial)* tile on the Applications tab.
4. In the Medical and Pharmacy Drug PA Portal, click the *Authorization* menu and select *Add New*.
5. Enter the member's last name, date of birth, subscriber ID and authorization start date.
6. Click *Search* and then select the appropriate member in the member list.
7. Complete all required fields and submit the request.

If you're registered for Availity Essentials™ but aren't able to access it, submit the prior authorization request using the *Medication Authorization Request Form*, or *MARF*, that's on the next page. Fax it to the number on the form.

Non-Michigan prescribers

When submitting prior authorization requests, prescribers located outside of Michigan should complete the appropriate steps on the Getting Started page on **ereferrals.bcbsm.com**. Look in the *Submit prior authorization requests* section.

If a non-Michigan prescriber is unable to submit a prior authorization request using the instructions on the webpage, submit the request using the *Medication Authorization Request Form*, or *MARF*, that's on the next page. Fax it to the number on the form.

Information about the Medical and Pharmacy Drug PA Portal

To help you learn how to use the Medical and Pharmacy Drug PA Portal, view a recorded demo by going to Blue Cross and BCN's Provider Training site, searching on *drugs* and launching the *Medical and Pharmacy Drug PA Portal Overview*.

For detailed information about accessing the Provider Training site, see the "Online training" section of the Training Tools page on **ereferrals.bcbsm.com.**

*Clicking this link means that you're leaving the Blue Cross Blue Shield of Michigan and Blue Care Network website. While we recommend this site, we're not responsible for its content.

Availity® is an independent company that contracts with Blue Cross Blue Shield of Michigan and Blue Care Network to offer provider portal and electronic data interchange services.

Blue Cross Blue Shield/Blue Care Network of Michigan
Medication Authorization Request Form
Givlaari™ (givosiran) HCPCS CODE: J0223

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This form is to be used by participating physicians to obtain coverage for Givlaari. 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 **Pt weight (in kg)** **Date recorded:**_____	**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. Initiation or Continuation of treatment? ☐ 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. Is Givlaari prescribed by or in consultation with a physician that has experience managing acute hepatic porphyria? ☐ Yes ☐ No Comment: _____
6. **Initiation AND Continuation of Therapy:**
   a. Please check the patient's diagnosis:
      i. ☐ Acute hepatic porphyria (AHP)
         1. Does AHP include any of the following?
         ☐ ALA-Dehydratase Deficiency Porphyria (ADP) ☐ Acute Intermittent Porphyria (AIP) ☐ Hereditary Corproporphyria (HCP)
         ☐ Variegate Porphyria (VP) ☐ Other
      ii. ☐ Other: _____
   b. How has the patient been diagnosed with AHP? *(labs are required)*
      ☐ Elevated urinary aminolevulinic acid (ALA): _____ µmol/L Date: _____
      ☐ Porphobilinogen (PBG) levels above the lab tests upper level of normal obtained during an acute attack: _____ µmol/L Date: _____
      ☐ Genetic testing positive for a mutation consistent with ADP, AIP, HCP, or VP: _____ Date: _____
      ☐ Other
   c. Does the patient have active disease with at least 2 documented porphyria attacks in the last 6 months? ☐ Yes ☐ No Comment: _____
   d. Does the patient have chronic baseline disease activity with symptoms such as:
      ☐ Pain in the abdomen, back, and/or chest ☐ Cardiovascular conditions including hypertension, and tachycardia
      ☐ Gastrointestinal involvement including nausea, vomiting, and constipation
      ☐ Neurological involvement including neuropathic pain, sensory loss, muscle weakness, paralysis, confusion, anxiety, depression, memory loss, fatigue, hallucinations, seizures
      ☐ Other system involvement including respiratory failure, skin lesions, hyponatremia
   e. Has the patient taken the appropriate lifestyle modifications to prevent acute attacks including but not limited to: dietary modifications, quitting smoking, stopping alcohol use, and removing medications known to cause acute attacks when possible? ☐ Yes ☐ No
   f. Has the patient had a previous liver transplant or an anticipated liver transplant? ☐ Yes ☐ No
7. **Continuation request:** Givlaari start date _____
   a. Has the patient had a reduction in the number of AHP attacks or baseline symptoms of AHP since starting therapy?
      ☐ Yes ☐ No Comment _____
   b. Has the patient received a liver transplant since starting Givlaari? ☐ Yes ☐ No

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	☐ Weight (specify lb or kg)
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**