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
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**

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