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

Hereditary Angioedema - Berinert® (C1 Esterase Inhibitor) J0597, Cinryze® (C1 Esterase Inhibitor) J0598, Kalbitor® (ecallantide) J1290, Firazyr® (icatibant) J1744, Ruconest® (C1 Esterase Inhibitor) J0596, Sajazir (icatibant acetate) J1744

This form is to be used by participating physicians to obtain coverage for Hereditary Angioedema Medications. 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. Is this for Initiation or Continuation of therapy? ☐ Initiation ☐ Continuation *Date patient started therapy:* _______________
2. Which product is being requested?
   ☐ Brand product (Berinert, Ruconest, Kalbitor, Firazyr) ☐ Generic product (Icatibant: generic Firazyr)
3. Who is administering this medication? ☐ Self-administration ☐ Health Care Professional
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: ☐ Hereditary Angioedema (HAE) ☐ Other: ____________________________
   b. What type of Hereditary Angioedema does the patient have?
      ☐ Type 1 ☐ Type 2 ☐ Type 3 ☐ Other: ___________________________
   c. How was the diagnosis of HAE confirmed? Note: values defined by the laboratory performing the test
      ☐ Normal C1q level, Please provide results: ____________________________
      ☐ C4 levels below the lower limit of normal, Please provide results: ______________________________
      ☐ C1INH antigenic level: Low, C1INH function: not fully functional, Please provide results: _______________________
      ☐ C1INH antigenic level: Normal/elevated, C1INH function: not fully functional, Please provide results: _______________
      ☐ Other; Please list alternative test used to confirm diagnosis AND how it confirms the diagnosis: __________________
   d. What is the primary indication this medication is being used to treat?
      ☐ Treatment of acute attack ☐ Long-term prophylaxis
      ☐ Short term prophylaxis ☐ Other: ________________________
   e. Please select which of the following applies to the patient and their need for short-term hereditary angioedema prophylaxis:
      ☐ Dental work ☐ Surgical procedures
      ☐ Invasive medical procedures ☐ Other: _______________________
   f. Does the patient have a history of attacks that are considered severe with swelling of the face, throat or gastrointestinal tract? ☐ Yes ☐ No
      i. If no, how many HAE attacks does the patient have per month? _________/month.
   g. ***Cinryze only for patients ≥ 12 years old:***
      Which of the following agents has the patient experienced treatment failure with for their condition?
      ☐ Haegarda ☐ Takhzyro ☐ Other, Please list name of the agent: __________________________
   h. **For Berinert, Ruconest, Kalbitor, and Firazyr only:** Has the patient experienced treatment failure with GENERIC Firazyr® (icatibant) for treatment of acute attacks?
      ☐ Yes, Please specify how the patient failed icatibant therapy (for example: side effects, lack of efficacy, etc.): ____
      ☐ No
   i. ***Ruconest only***: Has the patient had laryngeal attacks from hereditary angioedema (HAE)? ☐ Yes ☐ No
   j. Will the patient be using the drug requested in combination with other products indicated for acute hereditary angioedema (HAE) attacks (for example: Kalbitor, Berinert, Firazyr, Ruconest, or icatibant)? ☐ Yes ☐ No
   k. Will the patient be on prophylactic therapy (for example: Haegarda, Takhzyro, or Cinryze, etc.) for hereditary angioedema (HAE) if they have exceeded the total monthly quantity allowed, as defined by the BCBSM medical policy for acute HAE? ☐ Yes ☐ No
8. **Continuation of therapy: (please fill out above questions as well)**
   a. Has the patient demonstrated at least a 50% improvement of acute attacks symptoms and maintenance of symptoms? ☐ yes ☐ no
   b. For long term prophylaxis, how has the patient improved?
      ☐ 50% or greater reduction in HAE attacks ☐ Reduction in duration of attack ☐ Reduction in days of swelling ☐ 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	☐ Form Completely Filled Out ☐ Attached Chart Notes	☐ Concurrent Medical Problems ☐ Prior Therapies
Step 3: Submi	**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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