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

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

Blue Cross Blue Shield Blue Care Network of Michigan

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

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) ☐ Sajazir
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, Sajazir 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**

7/24/14; 12/1/14 Updated 10/15/15; 12/28/2016; 8/11/2017; 12/5/2017;10/11/2018; 11/1/2018; 6/26/2019; 3/26/2020; 10/1/2020;12/27/2021; 12/1/2022