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
Ilaris® (canakinumab) HCPCS CODE: J0638

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This form is to be used by participating physicians to obtain coverage for Ilaris. 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. 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. **Initiation AND Continuation of therapy:**
   a. Will the patient be receiving Ilaris with other biologic agents (for example: Kineret, Actemra or TNF inhibitors) or with targeted DMARD medications (for example: Otezla)? ☐ Yes ☐ No Comment: _____
   b. Please check the patient's diagnosis:
      ☐ Cryopyrin-Associated Periodic Syndromes (CAPS) with phenotypes: Familial Cold Auto-Inflammatory Syndrome (FACS) or Muckle-Wells Syndrome (MWS) *(go to c, d, and e)*
      ☐ Tumor Necrosis Factor Receptor Associated Periodic Syndrome (TRAPS)
      ☐ Systemic Juvenile Idiopathic Arthritis (SJIA) *(go to f)*
      ☐ Still's disease, including adult-onset Still's disease *(go to f)*
      ☐ Hyperimmunoglobulin D Syndrome (HIDS)/Mevalonate Kinase Deficiency (MKD)
      ☐ Familial Mediterranean Fever (FMF) *(go to g)*
      ☐ Other_____
   c. **CAPS:** How was CAPS diagnosed?
      ☐ Genetic testing (such as in the Cold-Induced Auto-inflammatory Syndrome 1 (CIAS1 – also referred to as the NLRP-3) **(please attach results)**
      ☐ Physical assessment **(please attach assessment)** ☐ Other: _____ ☐ N/A
   d. **CAPS**: Please provide ~~the~~ levels of C-reactive protein (CRP) and serum amyloid A ~~levels~~ with reference range:
      CRP:_____ Serum amyloid A: _____
   e. **CAPS:** Please check which classic symptoms the member is experiencing due to CAPS:
      ☐ Urticaria-like rash ☐ Cold-triggered episodes ☐ Sensorineural hearing loss ☐ Musculoskeletal symptoms ☐ Chronic aseptic meningitis
      ☐ Skeletal abnormalities ☐ Other: _____ ☐ None ☐ N/A
   f. **SJIA or Still's disease:** What medications has the patient tried and failed?
      ☐ Methotrexate ☐ Leflunomide ☐ NSAIDs ☐ Glucocorticoids ☐ Actemra ☐ Kineret ☐ Other: _____
   g. **FMF:** Has the patient tried and failed colchicine? ☐ Yes ☐ No Comment _____

6. **Continuation request:** Ilaris start date _____
   a. Has the patient's condition improved while on therapy with Ilaris?
      ☐ Yes ☐ No Comment _____

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: 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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01/21/14; 10/15/2015; 8/11/2017; 12/5/2017; 7/26/2018, 9/18/2018; 1/31/2020; 3/17/2020; 10/1/2020; 2/4/2021