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

Remicade® (infliximab) J1745, infliximab J1745, Inflectra™ (infliximab-dyyb) Q5103, Renflexis™ (infliximab-abda) Q5104, Avsola™ (infliximab-axxq) Q5121

Blue Cross Blue Shield Blue Care Network of Michigan

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This form is to be used by participating physicians to obtain coverage for Remicade, Inflectra, Renflexis, and Avsola. 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	**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 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. What is the Patient's weight in Kg? _____ Date recorded: _____
6. Primary Indication: ☐ Crohn's Disease **(See #7b)** ☐ Ulcerative Colitis **(See #7b)** ☐ Rheumatoid Arthritis **(See #7c)**
   ☐ Psoriatic Arthritis ☐ Plaque psoriasis **(See #7d)** ☐ Ankylosing spondylitis
   ☐ Generalized pustular psoriasis as defined by the European Rare and Severe Psoriasis Expert Network
   ☐ Other: _____
7. **Initiation AND Continuation of therapy**:
   a. Will the patient be receiving Remicade/Inflectra/Renflexis/Avsola with other biologic agents (for example: Humira, Kineret, Entyvio, or Tremfya, etc.) or with targeted DMARD medications (for example: Otezla)? ☐ Yes ☐ No, Comment:_____
   b. **Crohn's Disease AND Ulcerative colitis**
      i. Does the patient have Crohn's disease with fistula? ☐ Yes ☐ No
      ii. Which therapies has the patient tried and failed?
      ☐ Systemic corticosteroids (e.g. 40 to 60 mg prednisone, prednisolone) daily for 7 days
      ☐ Immunomodulatory therapy for at least 2 months (e.g. azathioprine, mercaptopurine, or methotrexate)
      ☐ None ☐ Other: _____
   c. **Rheumatoid Arthritis (RA:**
      iii. Has the patient had documented failure of at least 3 months of an oral DMARD? (e.g. hydroxychloroquine, methotrexate, leflunomide, or sulfasalazine)
      ☐ Yes, Length of therapy: _____ ☐ No
      iv. Will the patient be taking infliximab in combination with methotrexate? ☐ Yes ☐ No, Provide rationale: _____
   d. **Plaque Psoriasis**:
      i. Has the patient experienced treatment failure with one topical corticosteroid?
      ☐ Yes, Please list topical corticosteroids the patient has tried: _____
      ☐ No, Comment: _____
8. Which medication has the patient tried and failed at optimized dose? ☐ Inflectra ☐ Avsola ☐ Other: _____
   a. What was the maximum dose the patient received of Inflectra in mg/kg and frequency? _____
   b. What was the maximum dose the patient received of Avsola in mg/kg and frequency? _____
   c. How has the patient failed Inflectra and Avsola therapy?
   ☐ Hypersensitivity reaction (for example: hives during infusion), Please specify: _____
   ☐ Side effects, Please specify: _____
   ☐ Lack of efficacy (for example: abdominal pain, bloody stools, etc.), Please specify: _____
   ☐ Other, Please specify: _____
9. **Continuation Request:** Remicade/Inflectra/Renflexis/Avsola Start Date _____
   a. Has the patient's signs and symptoms improved with Remicade/Inflectra/Renflexis/Avsola? ☐ 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
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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1/31/2020; 7/1/2020; 2/4/2021; 12/9/2021; 10/7/2022