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 web-DENIS user

To request a drug prior authorization, please go to bcbsm.com and follow these easy steps:

Log into the Provider Portal

- Navigate to bcbsm.com, and enter your provided username and password in the Provider Secured Services box

Navigate to the Medication Prior Authorization Link

- Select the quick link on the left side of the webpage labeled "Medical Benefit-Medication Prior Authorization" or scroll down the center of the page to find a duplicate link

Enter your National Provider Identifier (NPI)

- Type in or select your NPI from the drop down list. Once you complete this step, you will be routed to Novologix

Complete the Prior Authorization Request

- Refer to BCBSM Prior Authorization Guide for instructions (accessible from the help menu under Blue Cross Blue Shield of Michigan).

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

Blue Cross Blue Shield Blue Care Network of Michigan

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Immune Globulin Replacement Therapy - Bivigam® (J1556), Carimune NF® (J1566), Cuvitru™ (J1555), Flebogamma® (J1572), Gammagard® (J1569), Gammaplex® (J1557), Gamunex® (J1561), Gammaked (J1561), Hizentra® (J1559), HyQvia® (J1575), Octagam® (J1568), Privigen® (J1459), Ig NOS (J1599) Panzyga® (J1599), Cutaquig® (J1551), Asceniv™ (J1554), Xembify (J1558)

This form is to be used by participating physicians to obtain coverage for immune globulin products. 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 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) **Initial or Continuation of therapy?** ☐ Initial ☐ Continuation ***Original Start date:*** _____

2) **How administered?** ☐ Self-administered ☐ Health care professional administered

3) Site of administration? ☐ Provider office/Home infusion ☐ Other: _____
☐ Hospital outpatient facility (go to #4) *Reason for Hospital Outpatient:* _____

4) Please provide the NPI number for the place of administration: _____

5) Please specify location of administration if hospital outpatient infusion? _____

6) Please provide the member's current weight (in kilograms) and height (in inches): _____

7) **Indication:** ☐ Primary Humoral Immunodeficiency Diseases Type: _____ ☐ Acute IDP (Guillain Barre)
☐ Chronic Inflammatory Demyelinating Polyneuropathy (IDP) ☐ Multifocal Motor Neuropathy
☐ Solid Organ Transplant ☐ Dermatomyositis ☐ Multiple myeloma ☐ Hypogammaglobulinemia
☐ Idiopathic Thrombocytopenic Purpura (ITP) ☐Chronic ☐ Acute ☐ Pregnancy ☐ HIV ☐ Bone Marrow Transplant
☐ Myasthenia Gravis ☐ Systemic Lupus Erythematosus ☐ Polymyositis ☐ Other_____

8) **Please fill out what pertains to patient AND give level:**

Test	Response	Levels	Date	Test	Response	Levels	Date
IgG	☐ low ☐ normal ☐ high	_____	_____	IgD	☐ low ☐ normal ☐ high	_____	_____
IgM	☐ low ☐ normal ☐ high	_____	_____	B cells	☐ low ☐ normal ☐ high	_____	_____
IgA	☐ low ☐ normal ☐ high	_____	_____	T cells	☐ low ☐ normal ☐ high	_____	_____
IgE	☐ low ☐ normal ☐ high	_____	_____	Platelet count _____/mm^3 Date: _____			

9) **Please check which boxes pertain to patient:** ☐ Unable to produce response to: ☐ protein antigen ☐carbohydrate antigen
☐ Recurrent infections ☐ Prophylactic Antibiotics ☐ Immunization with conjugate vaccine

10) **Please list past trials and failures of other conventional therapies:**

Prior Therapy	Dates of Therapy	Outcome/Reason for D/C
_____	_____ to _____	☐ Not tolerated ☐ Failure Explain: _____
_____	_____ to _____	☐ Not tolerated ☐ Failure Explain: _____
_____	_____ to _____	☐ Not tolerated ☐ Failure Explain: _____

11) **For continuation, check all that applies to response to therapy (please provide and attach applicable lab values)**
☐ Improved Please describe: _____
☐ Stable Please describe: _____
☐ Worse Please describe: _____
☐ No assessment available on file; Explain: _____

Chart notes are required for the processing of all requests. Please add any other supporting medical information.

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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