

## 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](https://www.availity.com/bcbsm), and following the steps.

**To request a drug prior authorization, please go to [bcbsm.com](https://www.bcbsm.com) and follow these easy steps:**

#### Log into the Availity

- Navigate to [availity.com](https://www.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**  
**Krystexxa® (pegloticase) HCPCS CODE: J2507**



This form is to be used by participating physicians to obtain coverage for Krystexxa. 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
<b>Name</b>	<b>Name</b>
<b>ID Number</b>	<b>Specialty</b>
<b>D.O.B.</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>Address</b>
<b>Diagnosis</b>	<b>City /State/Zip</b>
<b>Drug Name</b>	<b>Phone/Fax: P: (     ) -     F: (     ) -     </b>
<b>Dose and Quantity</b>	<b>NPI</b>
<b>Directions</b>	<b>Contact Person</b>
<b>Date of Service(s)</b>	<b>Contact Person Phone / Ext.</b>

**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. Please check the patient's diagnosis:  Chronic Gout  Hyperuricemia not associated with gout  
 Asymptomatic hyperuricemia  Other: \_\_\_\_\_
  - b. What gout symptoms has the patient experienced?  
 At least 2 or more gouty flares in previous 12 months  Presence of one or more tophi  
 Chronic gouty arthritis  Other: \_\_\_\_\_  None
  - c. What is the patient's uric acid level? \_\_\_\_\_ mg/dL Date: \_\_\_\_\_
  - d. Has the patient undertaken appropriate lifestyle modifications (for example: limiting alcohol consumption and discontinuing or changing other medications known to precipitate gout attacks when possible)?  
 yes  no Comment \_\_\_\_\_
  - e. What medications AND at what dose has the patient tried and failed?  
 Allopurinol Dose: \_\_\_\_\_ Date: \_\_\_\_\_  
 Uloric (febuxostat) Dose: \_\_\_\_\_ Date: \_\_\_\_\_  
 Probenecid Dose: \_\_\_\_\_ Date: \_\_\_\_\_  
 Other: \_\_\_\_\_
  - a. Will the patient be using Krystexxa in combination with oral urate-lowering therapies (for example: allopurinol, febuxostat, or probenecid)?  yes  no Comment \_\_\_\_\_
6. **Continuation request:** Krystexxa start date \_\_\_\_\_
  - a. Have the patient's signs and symptoms improved with Krystexxa?  
 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
<b>Step 2:</b> Checklist	<input type="checkbox"/> Form Completely Filled Out <input type="checkbox"/> Attached Chart Notes	<input type="checkbox"/> Concurrent Medical Problems <input type="checkbox"/> Prior Therapies
<b>Step 3:</b> Submit	<b>By Fax: BCBSM Specialty Pharmacy Mailbox 1-877-325-5979</b>	<b>By Mail: BCBSM Specialty Pharmacy Program P.O. Box 312320, Detroit, MI 48231-2320</b>

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