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
Palforzia™ (Peanut (Arachis hypogaea) Allergen Powder-dnfp) HCPCS CODE: J3590

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 Palforzia™. 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**
Patient weight (in kg)	Date recorded:_____	
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 treatment? ☐ Initiation ☐ Continuation *Date patient started therapy:* _____
2. Please provide the NPI number for the place of administration: _____
3. **Initiation AND Continuation of Therapy:**
   a. Please check the patient's diagnosis: ☐ Peanut allergy ☐ Other: _____
   b. Does the patient have a clinical history of allergic reaction following peanut consumption?
      ☐ Yes, Please provide the date: _____; What did the patient consume: _____;
      Details regarding the patient allergic reaction: _____
      ☐ no Comment _____
   c. Does the patient have documentation of a confirmed diagnosis of peanut allergy by one of the following?
      ☐ Peanut-specific skin prick test (SPT) Date: _____
      ☐ Peanut-specific IgE antibodies Date: _____
   d. Will the provider attest that the member will be on a peanut-avoidant diet while on Palforzia therapy?
      ☐ Yes ☐ No Comment _____
   e. Does the patient have a current prescription for epinephrine and access to an epinephrine autoinjector while using Palforzia?
      ☐ Yes ☐ No Comment _____
   f. Does the patient have severe or uncontrolled asthma?
      ☐ Yes ☐ No Comment _____
   g. Does the patient have eosinophilic esophagitis?
      ☐ Yes ☐ No Comment _____
   h. Has the patient had severe or life-threatening anaphylaxis in the past 60 days?
      ☐ Yes ☐ No Comment _____
   i. Will the patient be receiving Viaskin Peanut or other peanut desensitization therapy while on Palforzia?
      ☐ Yes ☐ No Comment: _____
4. **Continuation Request** (please answer questions above as well): Palforzia start date: _____
   a. Have all dose levels of up-dosing been completed before starting maintenance therapy?
      ☐ Yes ☐ No Comment: _____
   b. How has the patient improved while on Palforzia?
      ☐ Palforzia is providing clinical benefit ☐ 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: 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**

2/26/2020; 4/16/2020; 4/8/2021