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
Prolia™ HCPCS CODE: J0897

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 Prolia™. 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 treatment? ☐ 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:**
   a. Will the patient be using Prolia in combination with any anabolic bone modifying agent (for example: Forteo, Tymlos) or bisphosphonate (for example: Fosamax)?
      ☐ Yes ☐ No Comment _____
   b. Primary Indication: ☐ Osteoporosis ☐ Osteopenia ☐ High risk for fracture ☐ Prevention of skeletal related events ☐ Other _____
   c. Type of cancer: ☐ Breast cancer ☐ Prostate cancer ☐ No cancer diagnosis ☐ Other: _____
   d. Endocrine therapy: ☐ Androgen deprivation therapy ☐ Aromatase inhibitor therapy ☐ Other: _____
   e. Please complete the chart below with the patient's **T-scores:**

	Example	Before bisphosphonate	During bisphosphonate	Before Prolia	During Prolia
Date of scan	*12/15/2019*				
Spine T-score	*-2.5*				
Left Hip T-score	*-2.7*				
Right Hip T-score	*-2.3*				

   f. 10-year probability of hip fracture _____% major osteoporosis-related fracture _____%
   g. Has the patient had a non-traumatic fracture? ☐ Yes, please provide the date and location of the fracture: _____ ☐ No
   h. What is the patient's creatine clearance? _____ mL/min Date: _____
   i. Has the patient tried and failed bisphosphonates for at least 24 months?
      ☐ Yes, please provide the medication failed and dates by filling the table below (j) ☐ No, please state why?: _____
   j. Check the bisphosphonate(s) the patient received and dates of therapy and response to therapy:

Bisphosphonates	Dates of therapy	Outcome / Reason for Discontinuation
☐ Reclast/Zometa (zoledronic acid)	***Start:*** _____ ***End:*** _____	☐ Not tolerated ☐ Failure Explain: _____
☐ Aredia (pamidronate)	***Start:*** _____ ***End:*** _____	☐ Not tolerated ☐ Failure Explain: _____
☐ Boniva (ibandronate) ☐**IV** ☐**PO**	***Start:*** _____ ***End:*** _____	☐ Not tolerated ☐ Failure Explain: _____
☐ Fosamax (alendronate)	***Start:*** _____ ***End:*** _____	☐ Not tolerated ☐ Failure Explain: _____
☐ Actonel (risedronate)	***Start:*** _____ ***End:*** _____	☐ Not tolerated ☐ Failure Explain: _____
☐ Other _____	***Start:*** _____ ***End:*** _____	☐ Not tolerated ☐ Failure Explain: _____

6. **Continuation request** (please answer above questions as well): **Prolia start date:** _____
   a. Check all that applies for response to Prolia therapy (continuation only)
      Skeletal related events: ☐ None ☐ Radiation to bone ☐ Surgery to bone ☐ Pathologic fracture ☐ Spinal cord compression
      Fractures: ☐ None ☐ Osteoporotic Fractures ☐ Major Bone Fracture ☐ Unchanged CSC ☐ Other _____
   b. Please include an updated BMD test and provide T-score values on the chart **above (5d)**

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 ☐ BMD (prior to and after Prolia)	☐ Prior Trials (bisphosphonates) ☐ Concurrent medical problems ☐ Calcium level
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**

1/28/2016; 7/8/2016; 2/2/2018; 7/23/2018, 9/18/2018; 8/1/2019; 1/6/2020; 3/17/2020; 10/20/2021; 10/6/2022