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
Reblozyl® (luspatercept–aamt) HCPCS CODE: J0896

Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

This form is to be used by participating physicians to obtain coverage for Reblozyl. 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 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. Is this request for: ☐ 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**:** ☐ Beta thalassemia ☐ Myelodysplastic syndrome (MDS) ☐ Other: _____
   b. **Beta thalassemia:**
      i. How was the patient diagnosed with beta thalassemia? ***(Please attach any tests confirming diagnosis)***
         ☐ Genetic testing: _____ ☐ Other: _____
      ii. Does the patient have Hemoglobin S/β-thalassemia or α-thalassemia?
         ☐ Yes ☐ No Comment _____
      iii. Is the patient considered transfusion dependent with a history of at least 100 mL/kg/year of pRBCs in the previous two years?
         ☐ Yes ☐ No Comment _____
      iv. Is the patient managed under standard thalassemia guidelines with ≥ 8 transfusions of pRBCs per year in the previous two years?
         ☐ Yes ☐ no Comment: _____
   c. **Myelodysplastic syndrome (MDS):**
      i. Does the patient have anemia requiring at least 2 units of red blood cells over 8 weeks? ☐ Yes ☐ No
      ii. Please select the patient's World Health Organization (WHO)/French American British (FAB) with IPSS-R classification for MDS:
         ☐ Very low risk ☐ Low risk ☐ Intermediate risk ☐ High risk
      iii. Does the patient have ring sideroblast ≥ 15% of erythroid precursors in bone marrow OR ≥ 5% if the SF3B1 mutation is present? ☐ Yes ☐ No
      iv. Does the patient have less than 5% blasts in the bone marrow? ☐ Yes ☐ No
      v. Has the patient used erythropoietin or darbepoetin alpha? ☐ Yes ☐ No
         1. Provide the product name, dose, frequency, and length of therapy: _____
            a. What was the response to the treatment?
               ☐ Never responded ☐ Lost response ☐ Intolerance to treatment ☐ Adverse event ☐ Other: _____
         2. What is the patient's endogenous serum erythropoietin level in U/L? _____
      vi. Has the patient used any prior therapy with disease-modifying agents for underlying MDS disease (examples: immune-modulatory drug, hypomethylating agents, or immunosuppressive therapy)? ☐ Yes, Please provide the name of the drug: _____ ☐ No
      vii. Does the patient have MDS associated with del 5q cytogenetic abnormality? ☐ Yes ☐ No
      viii. Does the patient have secondary MDS known to have arisen as the result of chemical injury or treatment with chemotherapy and/or radiation for other diseases?
         ☐ Yes ☐ No
6. **Continuation request: Reblozyl start date**: _____
   ☐ Reduction in transfusions for transfusion dependent patients
   ☐ Increase in hemoglobin with non- transfusions patients
   ☐ Other: _____
   ☐ None
7. *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 ☐ Attach Chart Notes	☐ Attach Diagnostic Tests and Labs
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**

1/31/2020; 7/1/2020; 10/1/2020; 8/12/202; 10/7/2022