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
Signifor® LAR (pasireotide) HCPCS CODE: J2502

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This form is to be used by participating physicians to obtain coverage for Signifor LAR. 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 **Pt weight (in kg)** **Date recorded:**_____	**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 medication being administered by: ☐ Self (patient) ☐ Health care professional (physician/nurse)
2. Is the patient being seen by an Endocrinologist? ☐ yes ☐ no Specialty: _____
3. What is the patient's dose and frequency of requested therapy? _____
4. Is this request for: ☐ Initiation ☐ Continuation ***Original start date:*** _____
5. **Initiation AND Continuation of therapy:**
   a. Please check the patient's diagnosis: ☐ Acromegaly ☐ Cushings Disease
      ☐ Hormone secreting tumors of the GI tract ☐ Other: _____
   b. Has the patient had a poor response to surgery and/or is surgery not an option for them?
      ☐ yes ☐ no; Please explain: _____
   c. Does the patient have elevated insulin-like growth factor-1 (IGF-1)? *(Before treatment started)*
      ☐ yes, current level _____, date drawn: _____ ☐ no
   d. Please check which medications the patient has tried:
      ☐ Somatuline Depot ☐ Sandostatin
      ☐ Sandostatin LAR ☐ Somavert ☐ Other: _____
6. **Continuation request:** Signifor LAR start date: _____
   a. Has the patient had improvement in manifestations of acromegaly?
      ☐ yes ☐ no; Please explain: _____
   b. If the patient has improvement in manifestations of acromegaly, please check which apply:
      ☐ Decrease in Growth Hormone (GH) and/or IGF-1 levels
      ☐ Decrease in pituitary tumor size
      ☐ Other, explain: _____
7. Please attach any chart notes or additional documentation and submit to plan. ***(Required)***

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	☐ Patient and Physician Information complete
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**

9/22/2015; 11/20/2015; 2/2/2018;10/11/2018