

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
Soliris® (eculizumab) HCPCS CODE: J1300



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 Soliris. 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. <input type="checkbox"/> Male <input type="checkbox"/> 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. Will the patient be receiving Soliris concurrently with Ultomiris, Uplizna, Enspryng, Empaveli, immunoglobulin therapy (IVIG) or other medications to treat any of the diagnoses below?
 Yes No Comment: _____
 - b. Please check the patient's diagnosis: Atypical hemolytic uremic syndrome (aHUS) Paroxysmal nocturnal hemoglobinuria (PNH) Neuromyelitis optica spectrum disorder (NMOSD) Refractory generalized myasthenia gravis (gMG) Other _____
 - c. For **PNH**:
 - i. Does the patient have flow cytometric confirmation of PNH type III red cells? Yes, Please provide laboratory report for review: _____, Date: _____ No
 - ii. How many transfusions has the patient had in the previous 24 months (prior to Soliris)? _____
 - iii. Has the patient experienced a major adverse thrombotic vascular event from thromboembolism? Yes, List event: _____ No
 - iv. What is the patient's lactic dehydrogenase (LDH) level? _____ Units/L Date: _____ Lab's reference range: _____
 - v. Which of these symptoms does the patient experience? Weakness Fatigue Hemoglobinuria Abdominal pain Dyspnea Hemoglobin < 10 g/dL
 A major vascular event Dysphagia Erectile dysfunction Other _____
 - d. For **aHUS**:
 - i. Have common causes of typical hemolytic uremic syndrome been ruled out, including infectious causes of HUS and thrombotic thrombocytopenic purpura (TTP)? Yes No, Comment: _____
 - ii. What is the hemoglobin level prior to initiation of treatment? _____ g/dL Date: _____
 - iii. What is the platelet count prior to initiation of treatment? _____ /mm³ Date: _____
 - iv. Does the patient have evidence of hemolysis? Yes No Comment: _____
 1. If yes, what is the patient's lactic dehydrogenase (LDH) level? _____ Units/L Date: _____
 2. If yes, what is the patient's haptoglobin level? _____ mg/dL Date: _____
 3. If yes, does the patient have schistocytosis? Yes No Comment: _____
 - v. What is the patient's serum creatinine? _____ mg/dL Date: _____
 - vi. Is the patient currently undergoing dialysis? Yes No Comment: _____
 - e. For refractory **gMG**:
 - i. How has the patient been diagnosed with gMG? (**Please attach any tests confirming diagnosis**) Anti-AChR antibody test Edrophonium test
 Clinical response to oral cholinesterase inhibitors (ex. pyridostigmine) Repetitive nerve stimulation (RNS) Single-fiber electromyography (SFEMG) Other: _____
 - ii. Does the patient have a history of thymectomy within 12 months, current thymoma, or other neoplasms of the thymus? Yes, Date: _____ No
 - iii. What is the severity of the patient's MG? Class I Class II Class III Class IV Class V
 - iv. Has the patient tried and failed therapy with at least one conventional therapy?

<input type="checkbox"/> Methotrexate	Date started: _____	Date ended: _____
<input type="checkbox"/> Azathioprine	Date started: _____	Date ended: _____
<input type="checkbox"/> Cyclophosphamide	Date started: _____	Date ended: _____
<input type="checkbox"/> Cyclosporine	Date started: _____	Date ended: _____
<input type="checkbox"/> Mycophenolate mofetil	Date started: _____	Date ended: _____
<input type="checkbox"/> Tacrolimus	Date started: _____	Date ended: _____
<input type="checkbox"/> Other: _____	Date started: _____	Date ended: _____
 - v. Has the patient tried and failed Vyvgart? Yes No Comment: _____
 - vi. Is the patient currently receiving and will continue to receive a standard of care regimen for their diagnosis with Soliris? Yes No Comment: _____
 - f. For **NMOSD**:
 - i. Is the patient aquaporin-4 (AQP4) antibody positive? Yes No Comment: _____
 - ii. Has the patient tried and failed rituximab/rituximab biosimilars, Uplizna, and Enspryng?
 Yes, Please list: _____ No Comment: _____
6. **Continuation request:** Soliris start date _____
 - a. Has the patient's condition improved while on therapy with Soliris? Yes No Comment: _____

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	<input type="checkbox"/> Form Completely Filled Out <input type="checkbox"/> Attached Chart Notes	<input type="checkbox"/> Concurrent Medical Problems <input type="checkbox"/> 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

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