

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
Spinraza™ (nusinersen)
HPCS CODE : J2326



This form is to be used by participating physicians to obtain coverage for Spinraza. 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
Pt 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

- Is the prescriber a neurologist specializing in pediatric neuromuscular disorders? Yes No
If no, please list the consulting neurologist specializing in pediatric neuromuscular disorders: _____
- Is this for initiation or continuation of therapy? Initiation Continuation *Date patient started therapy: _____*
- Please provide the NPI number for the place of administration: _____
- Is the patient fully ventilator dependent? Yes No
- How often will the patient be receiving the maintenance dose (after the initial starting regimen):
 Every 2 months Every 4 months Every 6 months Other _____
- Has the clinical outcome information been provided within the Audaire Health provider portal as requested by BCBSM?
 Yes No *Comment _____*
- Initiation AND Continuation of Therapy:**
 - Please check the patient's diagnosis: Spinal muscular atrophy Other: _____
 - If spinal muscular atrophy chosen, what type does the patient have?
 Type 0 Type 1 Type 2 Type 3 Type 4
 - Has the patient been diagnosed with spinal muscular atrophy through genetic testing? (*labs are required*)
 Yes No
 - Has a baseline, age appropriate exam to establish baseline motor function and ability been submitted? Examples of assessments include: Hammersmith Infant Neurological Exam (HINE); Hammersmith Functional Motor Scale Expanded (HFMSE), etc. (*chart notes are required*) Yes No
 - Has the patient received prior treatment with any gene therapy (such as Zolgensma) or are they being considered for future treatment with gene therapy for spinal muscle atrophy? Yes No
 - Will the patient be receiving Spinraza with SMN2-targeting antisense oligonucleotide or SMN2 splicing modifier?
 Yes No
- Continuation request:** Spinraza start date _____
 - Has the patient repeated a motor ability assessment documenting clinically significant improvement in SMA-associated motor milestones and motor function compared to predicted natural history and progression? (*chart notes are required*)
 Yes No *Comment _____*

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	<input type="checkbox"/> Form Completely Filled Out <input type="checkbox"/> Attached Chart Notes	<input type="checkbox"/> Weight (specify lb or kg) , BSA
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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