

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](https://www.availity.com/bcbsm), and following the steps.

To request a drug prior authorization, please go to [bcbsm.com](https://www.bcbsm.com) and follow these easy steps:

Log into the Availity

- Navigate to [availity.com](https://www.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
Spravato™ (esketamine) HCPCS CODE: S0013



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 Spravato. 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: _____	City /State/Zip
Diagnosis	Phone/Fax: P: () - F: () -
Drug Name <input type="checkbox"/> Spravato	NPI
Dose and Quantity	Contact Person
Directions	Contact Person Phone / Ext.
Date of Service(s)	

STEP 1: DISEASE STATE INFORMATION

1. Is this an initial request or continuation of therapy? Initiation Continuation *Date patient started therapy:* _____
2. Please provide the NPI number for the place of administration: _____
3. **Initiation AND Continuation of therapy:**
 - a. Please check the patient's diagnosis: Resistant depression
 Depressive symptoms with major depressive disorder with acute suicidal ideation other: _____
 - b. Has the patient had tried and failed at least two different combinations of an oral antidepressant AND an augmentation therapy for at least 6 weeks? We require each combination to include a different antidepressant and a different augmentation therapy than previous combinations. (Augmentation therapies include but not limited to lithium, buspirone, and olanzapine)?
 Yes No **Comment** _____
 - i. Antidepressant therapy: _____ + Augmenting therapy: _____ Dates: _____ - _____
 - ii. Antidepressant therapy: _____ + Augmenting therapy: _____ Dates: _____ - _____
 - iii. Other: _____
 - c. Will the patient use Spravato with cognitive behavioral therapy or interpersonal psychotherapy weekly for at least 8 weeks of treatment?
 Yes No **Comment** _____
 - d. Please check concomitant medications the patient will be receiving while on Spravato:
 Duloxetine Sertraline Escitalopram Venlafaxine None Other: _____
 - i. Has the patient used the selected medication before without any benefit to their depression symptoms?
 Yes No **Comment:** _____
 - e. If Spravato is self-administered at home, will a healthcare provider be present?
 Yes No, Please provide rationale: _____
 - f. Will the patient be on Spravato with Ketamine IV?
 yes, Please provide rationale: _____ No
4. **Continuation request: Spravato start date:** _____
 - a. Has the patient had documented clinical response (improvement) to Spravato? Yes No **Comment:** _____
 - b. For acute suicidal ideation: no further authorization will be provided after 1 month of therapy.

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"/> Prior Treatments with other medications
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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