

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
Stelara® (ustekinumab) Intravenous HCPCS CODE: J3358**



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 Stelara. 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
Patient's weight (in kg) Date recorded: _____	City/State/Zip
Diagnosis	Phone/Fax: P: () - F: () -
Drug Name <input type="checkbox"/> Stelara Intravenous Only	NPI
Dose and Quantity	Contact Person
Directions	Contact Person Phone / Ext.
Date of Service(s)	

STEP 1: DISEASE STATE INFORMATION

****Please note: A separate form is required for Stelara Subcutaneous****

1. Has the patient already received Stelara IV? Yes No 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. What is the requested initial Stelara IV Dose based on patient's weight? Weight in kg: _____
 130 mg 260 mg 390 mg 520 mg Other: _____
6. **Initiation AND Continuation of therapy:**
 - a. Please check the patient's diagnosis: Crohn's disease Ulcerative colitis other: _____
 - b. Has the patient tried and failed therapy with at least one conventional therapy?
 - Systemic corticosteroid daily for 7 days: please list name of drug(s): _____, Date started: _____ Date ended: _____
 - Mercaptopurine, Date started: _____ Date ended: _____
 - Azathioprine, Date started: _____ Date ended: _____
 - Methotrexate, Date started: _____ Date ended: _____
 - Other: _____, Date started: _____ Date ended: _____
 - c. Will the patient be receiving Stelara with other biologic agents (for example: Remicade, Humira, Kineret, Entyvio, Tremfya, etc.) or with targeted DMARD medications (for example: Otezla)?
 yes, Please provide rationale: _____ no
7. Stelara IV is a one-time therapy and should not be used after the first dose. **Please see Stelara Subcutaneous request form for continued 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"/> 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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