

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, avility.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 avility.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

Xenpozyme™ (olipudase alfa-rpcp): J3490/3590



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 Xenpozyme. 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 of therapy *Date patient started therapy:* _____

2. Please provide the NPI number for the place of administration: _____

3. **Initiation AND Continuation of Therapy:**
 - a. What is the patient's diagnosis?
 - Non-central nervous system manifestations of acid sphingomyelinase deficiency (ASMD)
 - Other, list diagnosis: _____
 - b. How has the patient been diagnosed with ASMD? (***Please attach any tests confirming diagnosis***)
 - Biochemical assay showing decreased acid sphingomyelinase (ASM) activity in white blood cells
 - Skin fibroblasts less than 10% of normal, Results: _____ Date: _____
 - Genotyping revealing two pathogenic mutations of the SMPD1 gene
 - Other: _____
 - c. What type of disease does the patient have?
 - Type A/B
 - Type B
 - Other; Please specify: _____
 - d. What symptoms is the patient experiencing?
 - i. For Adults:
 - Diffusion capacity of the lungs for carbon monoxide (DLco) of less than or equal to 70% of the predicted normal value
 - A spleen volume greater than or equal to 6 times the normal (MN) measured volume by magnetic resonance imaging (MRI)
 - ii. For Pediatrics:
 - A spleen volume greater than or equal to 5 MN measured by MRI
 - Other: _____

4. **Continuation of therapy:**
 - a. If the patient is continuing therapy, please give the patient's current disease status since beginning treatment:
 - Improved: Please describe: _____
 - Stable; Please describe: _____
 - Worsened; Please describe: _____
 - Other; Please describe: _____

5. ***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"/> Diagnostic Tests Attached
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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