Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

How to submit prior authorization requests for medical benefit drugs

For Blue Cross commercial and BCN commercial

Revised May 2025

Follow these steps to submit prior authorization requests when prescribing most drugs covered under the medical benefit for Blue Cross Blue Shield of Michigan and Blue Care Network commercial members.

Note: The information below doesn't apply to oncology medical benefit drugs.

Michigan prescribers

To submit prior authorization requests electronically:

1. Log in to our provider portal (availity.com*).
2. Click *Payer Spaces* on the menu bar and click the BCBSM and BCN logo.
3. Click the *Medical/Pharm Drug Benefit Prior Auth (Commercial)* tile on the Applications tab.
4. In the Medical and Pharmacy Drug PA Portal, click the *Authorization* menu and select *Add New*.
5. Enter the member's last name, date of birth, subscriber ID and authorization start date.
6. Click *Search* and then select the appropriate member in the member list.
7. Complete all required fields and submit the request.

If you're registered for Availity Essentials™ but aren't able to access it, submit the prior authorization request using the *Medication Authorization Request Form*, or *MARF*, that's on the next page. Fax it to the number on the form.

Non-Michigan prescribers

When submitting prior authorization requests, prescribers located outside of Michigan should complete the appropriate steps on the Getting Started page on **ereferrals.bcbsm.com**. Look in the *Submit prior authorization requests* section.

If a non-Michigan prescriber is unable to submit a prior authorization request using the instructions on the webpage, submit the request using the *Medication Authorization Request Form*, or *MARF*, that's on the next page. Fax it to the number on the form.

Information about the Medical and Pharmacy Drug PA Portal

To help you learn how to use the Medical and Pharmacy Drug PA Portal, view a recorded demo by going to Blue Cross and BCN's Provider Training site, searching on *drugs* and launching the *Medical and Pharmacy Drug PA Portal Overview*.

For detailed information about accessing the Provider Training site, see the "Online training" section of the Training Tools page on **ereferrals.bcbsm.com.**

*Clicking this link means that you're leaving the Blue Cross Blue Shield of Michigan and Blue Care Network website. While we recommend this site, we're not responsible for its content.

Availity® is an independent company that contracts with Blue Cross Blue Shield of Michigan and Blue Care Network to offer provider portal and electronic data interchange services.

Blue Cross Blue Shield/Blue Care Network of Michigan
Medication Authorization Request Form
Xgeva® (denosumab) HCPCS CODE: J0897

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This form is to be used by participating physicians to obtain coverage for Xgeva®. 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. ☐Male ☐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. Initiation or Continuation of treatment? ☐ 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. Is the patient scheduled to receive IV/SQ chemotherapy on same day as Xgeva?
   ☐ Yes, Please specify how long patient will be on IV/SQs chemotherapy: _____ ☐ No
6. **Initiation and Continuation:**
   a. Primary Indication: ☐ Breast Cancer ☐ Prostate Cancer ☐ Giant Cell Tumor of the Bone (go to h then i) ☐ Other solid tumor: _____
      ☐ Hypercalcemia of malignancy (HCM) ☐ Multiple Myeloma ☐ Other: _____
   b. Site of Metastases: ☐ None ☐ Bone metastases ☐ Other metastases _____
   c. Did the patient receive radiation to the bone? ☐ Yes ☐ No
      i. If yes, please specify the site and date of radiation: _____
   d. **HCM**: Most current corrected serum calcium (CSC) level _____mg/dL Test result date _____
   e. What IV bisphosphonate(s) has the patient received and dates of therapy?
      ☐ Reclast/Zometa (zoledronic acid) ***Start:***_____ ***End:***_____
      ☐ Aredia (pamidronate) ***Start:***_____ ***End:***_____
      ☐ *Other:* _____
   f. Why couldn't the member continue on intravenous bisphosphonate therapy?
      ☐ Therapy Failure (HCM: unchanged or increase in corrected serum calcium levels, Bone Mets/MM: new skeletal related events [radiation or surgery to bone, pathologic fracture of spinal cord])
      ☐ Contraindication (go to g)
      ☐ Intolerable side effect(s) (go to g)
      ☐ Other, Please list duration of treatment and describe why bisphosphonate therapy could not be continued:
      _____
   g. Which of the following contraindications or side effects has the member experienced while on bisphosphonate therapy?
      ☐ Creatinine clearance less than 30 ml/min
      ☐ Documented hypersensitivity to the medication
      ☐ Documented history of jaw necrosis
      ☐ Bone pain
      ☐ Flu-Like symptoms
      ☐ Other, Please provide the contraindication to bisphosphonate therapy: _____
   h. How was the diagnosis of **giant cell tumor of the bone** confirmed?
      ☐ CT Scan ☐ MRI ☐ Other: _____
   i. Is the **giant cell tumor of the bone** unresectable or would surgical resection likely result in severe morbidity? ☐ Yes ☐ No
7. **Continuation**: What has the patient experienced since beginning Xgeva therapy? **Xgeva start date:** _____
   ☐ Absence of skeletal related events ☐ Decreased in CSC levels from baseline ☐ Disease stabilization ☐ Pathological fracture
   ☐ Increased or unchanged CSC ☐ Other: _____

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	☐ Form Completely Filled Out ☐ Attached Chart Notes ☐ Calcium level	☐ Prior Trials (IV bisphosphonates) ☐ Concurrent medical problems
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**

1/28/2016; 2/2/2018; 7/16/2018, 9/18/2018; 3/21/2019