Blue Cross Blue Shield of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

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
Xgeva® (denosumab) HCPCS CODE: J0897

Blue Cross Blue Shield Blue Care Network of Michigan

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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