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
Xolair® (omalizumab) HCPCS CODE: J2357

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 Xolair®. 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 **Pt weight (in kg)** **Date recorded:**_____	**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 for Initiation or Continuation of therapy? ☐ Initiation ☐ Continuation *Date patient started therapy:* _____
2. How is this medication being administered? ☐ Self-administered ***(Please fax this completed form to BCBSM at (866) 601-4425)***
   ☐ Healthcare professional administered ***(Continue to #4)***
3. Will the patient receive the first 3 doses under the guidance of a health care provider? ☐ Yes ☐ No Comment: _____
4. Site of administration? ☐ Provider office/Home infusion ☐ Other: _____
   ☐ Hospital outpatient facility (go to #4) *Reason for Hospital Outpatient administration:* _____
5. Please specify location of administration if hospital outpatient infusion: _____
6. Please provide the NPI number for the place of administration: _____
7. **Initiation AND Continuation of therapy:**
   a. Will the patient be using Xolair in combination with other biologic agents (for example: Nucala, Fasenra, Cinqair or Dupixent) or targeted DMARD medications?
      ☐ Yes ☐ No Comment _____
   b. **Please check the patient's diagnosis:** ☐ Moderate to Severe Allergic Asthma (AA, *go to c then d)* ☐ Nasal polyps (go to c then i) ☐ Chronic idiopathic urticaria *(CIU, go to f)*
      ☐ Other _____
   c. What is the patient's IgE level at the start of therapy? _____IU/mL_ Date: _____
   d. **AA:** Which of the following tests did the patient receive for the diagnosis of moderate to severe allergic asthma?
      ☐ Positive skin test to a perennial aeroallergen (allergens with year-round exposure which may include molds, dust mites, cock roaches, animal feathers or dander, etc.)
      ☐ In-vitro reactivity to a perennial aeroallergen (allergens with year-round exposure which may include molds, dust mites, cock roaches, animal feathers or dander, etc.)
      ☐ N/A ☐ Other: _____
   e. **AA:** Which treatment(s) did not adequately control the patient's severe allergic asthma symptoms after a trial of at least 3 months?
      ☐ Systemic corticosteroid: _____ Date: *Start:* _____ *End:* _____
      ☐ High dose inhaled corticosteroids: _____ Date: *Start:* _____ *End:* _____
      ☐ Long acting beta2-agonist: _____ Date: *Start:* _____ *End:* _____
      ☐ Leukotriene receptor antagonist: _____ Date: *Start:* _____ *End:* _____
      ☐ Combination asthma inhaler with a HIGH dose corticosteroid and a long acting beta agonist: _____ Date: *Start:* _____ *End:* _____
      ☐ Combination asthma inhaler with a MEDIUM dose corticosteroid and a long acting beta agonist: _____ Date: *Start:* _____ *End:* _____
      ☐ Long acting muscarinic antagonist (LAMA): _____ Date: *Start:* _____ *End:* _____
      ☐ Other: _____ Date: *Start:* _____ *End:* _____
   f. **Chronic Idiopathic Urticaria (CIU):** How long has the patient been experiencing hives and itching (occurring daily or almost daily) in weeks?
      ☐ ≥ 6 weeks ☐ < 6 weeks ☐ Other: _____
   g. **CIU:** Have other diagnoses (such as Atopic Dermatitis, Contact Dermatitis, and reversible triggers) been ruled out? ☐ Yes ☐ No Comment: _____
   h. **CIU:** Which medications did the patient try and experience treatment failure at maximally tolerated doses for at least 2 months?
      ☐ 1st Generation Antihistamine drug and dose (such as Benadryl): _____ ***Start:*** _____ ***End:*** _____
      ☐ 2nd Generation Antihistamine drug and dose (such as: Zyrtec, Claritin, Allegra): _____ ***Start:*** _____ ***End:*** _____
      ☐ H2 antagonist drug and dose (such as: Zantac or Pepcid): _____ ***Start:*** _____ ***End:*** _____
      ☐ Leukotriene receptor antagonist (such as: Singulair): _____ ***Start:*** _____ ***End:*** _____
      ☐ Hydroxyzine ***Start:*** _____ ***End:*** _____
      ☐ Doxepin ***Start:*** _____ ***End:*** _____
      ☐ Other: _____
   i. **Nasal polyps:** Is the patient currently receiving and will continue to receive a standard of care regimen for their diagnosis with Xolair?
      ☐ Yes ☐ No Comment: _____
   j. **Nasal polyps:** Has the patient tried and failed intranasal corticosteroids? ☐ Yes ☐ No Comment: _____
8. **Continuation request** (please answer above questions as well): **Xolair start date:** _____
   a. Have the patient's signs and symptoms improved with Xolair?
      ☐ Yes ☐ No, Comment: _____ ☐ Other: _____
   b. Please provide reason(s) why the patient needs to continue Xolair administered by a healthcare professional:
      ☐ Prior history of anaphylaxis including to Xolair, or other agents such as foods, drugs, or biologics
      ☐ Hypersensitivity reactions during the first 3 doses under the guidance of a healthcare provider
      ☐ Patients or caregivers who are unable to recognize symptoms of anaphylaxis
      ☐ Patients or caregivers who are unable to treat anaphylaxis appropriately
      ☐ Patients or caregivers who are unable to perform subcutaneous injections with proper technique
      ☐ 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	☐ Attach Diagnostic Tests
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**

2/4/2021; 10/7/2021; 10/6/2022