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
Zynteglo® (betibeglogene autotemcel)
HCPCS CODE: J3490/J3590

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 Zynteglo. 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	☐ Zolgensma	**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. Has patient previously received Zynteglo or other gene therapy? ☐ Yes ☐ No Comment: _____
2. Please provide the NPI number for the place of administration: _____
3. Please specify the location of administration (e.g. name of facility): _____
4. Has the clinical outcome information been provided within the Audaire Health provider portal as requested by BCBSM?
   ☐ Yes ☐ No Comment: _____
5. **Initiation AND Continuation of therapy:**
   a. What is the patient's diagnosis?
      ☐ β-thalassemia who require regular red blood cell (RBC) transfusions
      ☐ Other – *please specify diagnosis:* _____
   b. How was the patient diagnosed with β-thalassemia? ***(Please attach any tests confirming diagnosis)***
      ☐ Genetic testing: _____ ☐ Other: _____
   c. Does the patient have Hemoglobin S/β-thalassemia or α-thalassemia?
      ☐ Yes ☐ No Comment _____
   d. Is the patient considered transfusion dependent with a history of at least 100 mL/kg/year of pRBCs in the previous two years?
      ☐ Yes ☐ No Comment _____
   e. Is the patient managed under standard thalassemia guidelines with ≥ 8 transfusions of pRBCs per year in the previous two years?
      ☐ Yes ☐ no Comment: _____
   f. Does the patient have any of the following?
      ☐ A prior hematopoietic stem cell transplant (HSCT) or currently be eligible for a HSCT with a willing and able HLA matched donor as determined by a hematologist and/or stem cell transplant specialist
      ☐ Presence of HIV-1 or HIV-2 infection
      ☐ Any prior malignancy with the exception of adequately treated cone-biopsied in situ carcinoma of the cervix uteri and basal or squamous cell carcinoma of the skin
      ☐ Myeloproliferative or significant immunodeficiency disorder unless patients meet any of the following:
         ☐ Vaccinated against hepatitis B (hepatitis B surface antibody-positive) and negative for other markers of prior hepatitis B infection
         ☐ Had past exposure to HBV but were negative by assessment for HBV DNA
         ☐ Are positive for anti-hepatitis C antibodies and have negative HCV viral load
      ☐ Uncorrected bleeding disorder
      ☐ Advanced liver disease defined AS:
         ☐ Alanine transferases or direct bilirubin greater than 3 times the upper limit of normal (ULN)
         ☐ Baseline prothrombin time or partial thromboplastin time greater than 1.5 times the ULN suspected of arising from liver disease
         ☐ Magnetic resonance imaging (MRI) of the liver demonstrating clear evidence of cirrhosis
   g. Has the patient received prior treatment with any gene therapy or is being considered for treatment with any other gene therapy for beta-thalassemia?
      ☐ Yes ☐ No Comment: _____
6. **Continuation of therapy** - *Please include rationale for continuation of therapy*_____
7. *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 necessary chart notes	☐ Important laboratory results
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**