

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 and Pharmacy Benefit Drug Prior Auth* 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 authorizations.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 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 Prior Auth portal overview mini module*.

For detailed information about accessing the Provider Training site, see the "Online training" section of the [Training Tools](#) page on authorizations.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**



This form is to be used by participating physicians to obtain coverage for **drugs covered under the medical benefit**. 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.	____/____/____ MM/DD/YYYY → Male → Female	Address	
Diagnosis		City /State/Zip	
Drug Name	Durolane, Euflexxa, GelSyn-3, GenVisc 850, Gel-ONE, Hyalgan, Visco-3, Supartz, Hymovis, Monovisc, Orthovisc, Synojoynt, Triluron	Phone: Fax:	
Dose and Quantity		NPI	
Directions		Contact Person	
Date of Service(s)		Contact Person Phone / Ext.	

STEP 1: DISEASE STATE INFORMATION

Required Demographic Information:

Patient Weight: _____ kg

Patient Height: _____ ft _____ inches

Will the provider be administering the medication to the FEP member within the health plan's geographic service area? →
Yes → No *If No, a prior authorization is not required through this process.*

Prior authorizations are required for FEP members that will be serviced by a provider within the health plan's geographic service area. If you are not a provider in the geographic service area, please contact the health plan for questions regarding the FEP member's benefit requirements.

Is this member's FEP coverage primary or secondary coverage? →

If primary, continue with question set.

→ If secondary, **an authorization is not needed through this process. Please contact the member's primary coverage for determination of benefit and additional information.**

Criteria Questions:

Please select medication:

 Hyaluronic Acids

- Durolane
- Euflexxa
- GelSyn-3
- GenVisc 850
- Gel-ONE
- Hyalgan
- Visco-3
- Supartz
- Hymovis
- Monovisc
- Orthovisc
- Synojoynt
- Triluron

1. What is the patient's diagnosis?

- Knee osteoarthritis
- Other diagnosis (*please specify*): _____

IF INITIATION, GO TO #2; IF CONTINUATION, GO TO #7**2. Has the patient experienced treatment failure with TWO or more of the following non-pharmacologic therapy?**

- Cardiovascular (aerobic) activity such as walking, biking, aquatic exercise
- Resistance exercise
- Weight reduction (if overweight)
- Participation in self-management programs
- Wear of medially directed patellar taping
- Wear of wedged insoles
- Thermal agents
- Walking aids
- Physical therapy
- Occupational therapy

Yes No; Go to #3**3. Has the patient experienced treatment failure, intolerance or contraindication to TWO or more of the following pharmacologic therapy?**

- Acetaminophen (Tylenol)
- Oral NSAIDs (for example, Ibuprofen, naproxen)
- Topical NSAIDs (for example, diclofenac [Voltaren gel])

Yes No; Go to #4**4. Has the patient experienced treatment failure, intolerance or contraindication to intra-articular steroid injections that were effective for LESS THAN 8 weeks?**Yes No; Go to #5**5. Does the patient have a radiologic confirmation of Kellgren-Lawrence Scale score of grade 2 OR GREATER?**Yes No; Go to #XX**6. Will the patient be receiving this drug with another hyaluronic acid injectable?**Yes No

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CONTINUATION OF THERAPY

7. Has the patient experienced a documentation of improvement with the previous course of therapy?

Yes No; Go to #XX

8. Has AT LEAST 12 months gone by since the last injection of the prior treatment cycle?

Yes No

9. Has there been a reduction in the use of NSAIDS (such as ibuprofen, naproxen) or other analgesics during the 12-month period following the last hyaluronic acid injection?

Yes No

10. Will the patient be receiving this drug with another hyaluronic acid injectable?

Yes No

Chart notes are required for the processing of all requests. Please add any other supporting medical information necessary for our review (required)

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 ➔ Provide chart notes	➔ Attach test 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