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
Benlysta ® (Belimumab) HCPCS CODE: J0490

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This form is to be used by participating physicians to obtain coverage for Benlysta®. For commercial members only, please complete this form and submit via fax to 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. Is this request for: ☐ 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)***
   ☐ Health Care Professional administered ***(Continue to #3)***
3. Site of administration? ☐ Provider office/Home infusion ☐ Other: _____
   ☐ Hospital outpatient facility (go to #4) *Reason for Hospital Outpatient:* _____
4. **Please specify location of administration if hospital outpatient infusion:** _____
5. **Please provide the NPI number for the place of administration:** _____

6. **Initiation AND Continuation of therapy:**
   a. Please check the patient's diagnosis**:** ☐ Systemic lupus erythematosus ☐ Active lupus nephritis ☐ Other: _____
   b. Did the patient test positive for serum antibodies at 2 separate times?
      ☐ Yes, Positive test 1: _____ Date Drawn: _____
      Positive test 2:_____ Date Drawn: _____
      ☐ No, Please list alternative test used to confirm diagnosis AND how it confirms the diagnosis: _____
   c. Does the patient have active disease?
      ☐ Yes, Please specify: _____ ☐ No
   d. Does the patient have lupus nephritis only with no other symptoms of systemic lupus erythematosus? ☐ Yes ☐ No
      If Yes, Please provide biopsy results confirming active kidney disease: _____
   e. Does the patient have active central nervous system lupus [for example: seizures, psychosis, stroke, cerebritis (infection of the brain)]?
      ☐ Yes ☐ No
   f. Which of the following medications has the patient previously been treated with for a course of at least 12 weeks and failed?
      ☐ Chloroquine ☐ Hydroxychloroquine ☐ Methotrexate ☐ Azathioprine ☐ Cyclophosphamide ☐ Mycophenolate mofetil ☐ None
      ☐ Other: _____
   g. Please select other medications the patient will be receiving while on Benlysta:
      ☐ Antimalarials ☐ Corticosteroids ☐ Non-biologic immunosuppressives ☐ None ☐ Other: _____
   h. Will the patient be using Benlysta in combination with other biologics (for example: Humira)?
      ☐ Yes ☐ No

7. **Continuation request:** (please answer above questions as well): **Benlysta start date**: _____
   Does the patient have improvement of disease while on therapy?
   ☐ Yes
   ☐ No
   ☐ 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	☐ ANA titer ☐ Anti-dsDNA	☐ SELENA-SLEDAI/BILAG score ☐ Urine Analysis
Step 3 Submit	**By Fax: BCBSM Specialty Pharmacy Mailbox (877) 325-5979**		**By Mail: BCBSM Specialty Pharmacy Program P.O. Box 312320, Detroit, MI 48231-2320**

1/28/2016; 8/11/2017; 12/5/2017;10/11/2018; 1/31/2020; 3/17/2020; 7/1/2020; 2/4/2021