

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 (availability.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
Crysvita® (burosumab-twza) HCPCS CODE: J0584



Nonprofit corporations and independent licensees
of the Blue Cross and Blue Shield Association

This form is to be used by participating physicians to obtain coverage for Crysvita. 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
Pt weight (in kg) Date recorded: _____	
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

- Is this request for initiation or renewal of therapy? ☐ Initiation ☐ Continuation ☐ Date patient started therapy: _____
- Site of administration? ☐ Provider office/Home infusion ☐ Other: _____
☐ Hospital outpatient facility (go to #3) Reason for Hospital Outpatient administration: _____
- Please specify location of administration if hospital outpatient infusion: _____
- Please provide the NPI number for the place of administration: _____
- Initiation AND Continuation of therapy:**
 - Please check the patient's diagnosis:
 - ☐ X-linked hypophosphatemia (XLH)
 - ☐ Treatment of FGF23-related hypophosphatemia in tumor induced osteomalacia (TIO)
 - ☐ Other: _____
 - XLH:
 - Genetic testing to confirm diagnosis: _____ (Please attach any tests confirming diagnosis)
 - Please provide serum fibroblast growth factor 23 (FGF23) level: _____ Date: _____
 - Please provide the serum Phosphorus level in mg/dL: _____ Date: _____
 - Please provide the measurable bone/joint pain (BPI-Q3 score): _____ Date: _____
 - What is the patient clinical signs and symptoms of the disease? ☐ Rickets ☐ Growth retardation ☐ Musculoskeletal pain
☐ Bone fractures ☐ Other: _____
 - Is the FGF23-related hypophosphatemia in TIO associated with phosphaturic mesenchymal tumors that cannot be resected or localized?
 - ☐ Yes ☐ No Comment: _____
 - Please provide serum fibroblast growth factor 23 (FGF23) level: _____ Date: _____
 - Please provide the serum phosphorus level in mg/dL: _____ Date: _____
 - Please provide the ratio of renal tubular maximum reabsorption rate of phosphate to glomerular filtration rate (TmP/GFR):
 _____ Date: _____ Normal reference range: _____
 - What is the patient clinical signs and symptoms of the disease? ☐ Bone pain ☐ Fractures ☐ Difficulty walking
☐ Muscle weakness ☐ Fatigue ☐ Other: _____
 - Please select which drugs has the patient tried and failed for the requested indication: _____
☐ Vitamin D ☐ Phosphate supplements ☐ Other: _____
- Continuation request:** Crysvita start date: _____
 - Has the patient had documented beneficial clinical response to Crysvita?
 - ☐ Yes ☐ No Comment: _____
 - How has the patient improved on therapy? ☐ Normalization of serum phosphate ☐ Enhanced height velocity
☐ Improvement in skeletal deformities ☐ Reduction of fractures ☐ Reduction of generalized bone pain
☐ Other: _____ ☐ None
- 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	☐ Serum Pi level	
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

Confidentiality notice: This transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reliance on the contents of this document is strictly prohibited. If you have received this in error, please notify the sender to arrange for the return of this document.