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 October 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 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
Efgartigimod Products
Vyvgart® (efgartigimod alfa-fcab) J9332, Vyvgart® Hytrulo (efgartigimod alfa and hyaluronidase-qvfc) J9334

Blue Cross Blue Shield Blue Care Network of Michigan

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 Vyvgart. 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
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. Who will be administering this medication? ☐ Healthcare provider/ nurse
   ☐ Self- Administered

3. Site of administration? ☐ Provider office/Home infusion ☐ Other: _____
   ☐ Hospital outpatient facility (go to #3) Re*ason for Hospital Outpatient administration:* _____

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: ☐ Generalized myasthenia gravis with anti-acetylcholine receptor (AChR) positivity
      ☐ Other: _____
   b. How was the patient identified to be anti-acetylcholine receptor (AChR) antibody-positive? ***(Please attach any tests confirming diagnosis)***
      ☐ Anti-AChR antibody test ☐ Edrophonium test ☐ Clinical response to oral cholinesterase inhibitors (ex. pyridostigmine)
      ☐ Repetitive nerve stimulation (RNS) ☐ Single-fiber electromyography (SFEMG) ☐ Other:_____
   c. Does the patient have a history of thymectomy within 3 months, current thymoma, or other neoplasms of the thymus?
      ☐ Yes, Please specify: _____ ☐ No
   d. Which medication did the patient trial and fail for at least 12 weeks?
      ☐ Methotrexate, Date started: _____ Date ended: _____
      ☐ Azathioprine, Date started: _____ Date ended: _____
      ☐ Cyclosporine, Date started: _____ Date ended: _____
      ☐ Cyclophosphamide, Date started: _____ Date ended: _____
      ☐ Mycophenolate mofetil, Date started: _____ Date ended: _____
      ☐ Tacrolimus, Date started: _____ Date ended: _____
      ☐ Other: _____, Date started: _____ Date ended: _____
   e. Is the patient currently receiving and will continue to receive a standard of care regimen for their diagnosis?
      ☐ Yes ☐ No Comment: _____
   f. Will the patient be receiving Efgartigimod concurrently with other biologic therapies for myasthenia gravis or immunoglobulin therapy?
      ☐ Yes ☐ no Comment: _____

7. **Continuation request:** Efgartigimod start date _____
   a. Has the patient's condition improved while on therapy with Efgartigimod? ☐ Yes ☐ No Comment
      _____

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	☐ Concurrent Medical Problems ☐ Prior Therapies
Step 3: Submt	**By Fax: BCBSM Specialty Pharmacy Mailbox** **1-877-325-5979**	**By Mail: BCBSM Specialty Pharmacy Program** **P.O. Box 312320, Detroit, MI 48231-2320**