

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
Hemgenix® (etranacogene dezaparvovec-drlb)
HCPSC CODE: J1411



This form is to be used by participating physicians to obtain coverage for Hemgenix. 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 ☐ Hemgenix	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 for initiation or continuation of therapy?
☐ Initiation ☐ Continuation *Date patient started therapy:* _____
- Please provide the NPI number for the place of administration: _____
- Please specify the location of administration (e.g. name of facility):

- Is this medication prescribed by or in consultation with a hematologist? ☐ Yes ☐ No *Comment:* _____
- Initiation AND Continuation of therapy:**
 - What is the patient's diagnosis?
☐ Hemophilia B (congenital Factor IX deficiency) confirmed via factor IX assay showing decreased factor IX levels
☐ Other – *please specify diagnosis:* _____
 - Has the patient had their adeno-associated virus stereotypic 5 vector (AAV5) antibody titer tested?
☐ Yes ☐ No *Comment:* _____
 - Does the patient have severe disease defined as a factor IX levels less than 5% of normal?
☐ Yes, Please specify IX level: _____ ☐ No ☐ Unknown
 - Is the patient currently on factor IX therapy with greater than 150 prior exposure days to treatment?
☐ Yes, Please specify number of exposure days to treatment: _____ ☐ No ☐ Unknown
 - Does the patient have a history of inhibitors to factor IX?
☐ Yes, Please specify: _____ ☐ No ☐ Unknown
 - Does the patient have a history of a positive inhibitor screen defined as greater than or equal to 0.3 Bethesda units prior to administration of Hemgenix?
☐ Yes, Please specify: _____ ☐ No ☐ Unknown
 - Has the patient received prior treatment with any gene therapy for hemophilia B or is being considered for treatment with any other gene therapy for hemophilia B? ☐ Yes ☐ No *Comment:* _____
- Continuation of therapy** - *Please include rationale for continuation of therapy* _____
- 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

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