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

Blue Cross Blue Shield Blue Care Network of Michigan

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Immune Globulin Replacement Therapy - Bivigam® (J1556), Carimune NF® (J1566), Cuvitru™ (J1555), Flebogamma® (J1572), Gammagard® (J1569), Gammaplex® (J1557), Gamunex® (J1561), Gammaked (J1561), Hizentra® (J1559), HyQvia® (J1575), Octagam® (J1568), Privigen® (J1459), Ig NOS (J1599) Panzyga® (J1576), Cutaquig® (J1551), Asceniv™ (J1554), Xembify (J1558), Alyglo™ (J1552)

This form is to be used by participating physicians to obtain coverage for immune globulin products. 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 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) **Initial or Continuation of therapy?** ☐ Initial ☐ Continuation ***Original Start date:*** _____

2) **How administered?** ☐ Self-administered ☐ Health care professional administered

3) Site of administration? ☐ Provider office/Home infusion ☐ Other: _____
☐ Hospital outpatient facility (go to #4) *Reason for Hospital Outpatient:* _____

4) Please provide the NPI number for the place of administration: _____

5) Please specify location of administration if hospital outpatient infusion? _____

6) Please provide the member's current weight (in kilograms) and height (in inches): _____

7) **Indication:** ☐ Primary Humoral Immunodeficiency Diseases Type: _____ ☐ Acute IDP (Guillain Barre)
☐ Chronic Inflammatory Demyelinating Polyneuropathy (IDP) ☐ Multifocal Motor Neuropathy
☐ Solid Organ Transplant ☐ Dermatomyositis ☐ Multiple myeloma ☐ Hypogammaglobulinemia
☐ Idiopathic Thrombocytopenic Purpura (ITP) ☐Chronic ☐ Acute ☐ Pregnancy ☐ HIV ☐ Bone Marrow Transplant
☐ Myasthenia Gravis ☐ Systemic Lupus Erythematosus ☐ Polymyositis ☐ Other_____

8) **Please fill out what pertains to patient AND give level:**

Test	Response	Levels	Date	Test	Response	Levels	Date
IgG	☐ low ☐ normal ☐ high	_____	_____	IgD	☐ low ☐ normal ☐ high	_____	_____
IgM	☐ low ☐ normal ☐ high	_____	_____	B cells	☐ low ☐ normal ☐ high	_____	_____
IgA	☐ low ☐ normal ☐ high	_____	_____	T cells	☐ low ☐ normal ☐ high	_____	_____
IgE	☐ low ☐ normal ☐ high	_____	_____	Platelet count _____/mm^3 Date: _____			

9) **Please check which boxes pertain to patient:** ☐ Unable to produce response to: ☐ protein antigen ☐carbohydrate antigen
☐ Recurrent infections ☐ Prophylactic Antibiotics ☐ Immunization with conjugate vaccine

10) **Please list past trials and failures of other conventional therapies:**

Prior Therapy	Dates of Therapy	Outcome/Reason for D/C
_____	_____ to _____	☐ Not tolerated ☐ Failure Explain: _____
_____	_____ to _____	☐ Not tolerated ☐ Failure Explain: _____
_____	_____ to _____	☐ Not tolerated ☐ Failure Explain: _____

11) **For continuation, check all that applies to response to therapy (please provide and attach applicable lab values)**
☐ Improved Please describe: _____
☐ Stable Please describe: _____
☐ Worse Please describe: _____
☐ No assessment available on file; Explain: _____

Chart notes are required for the processing of all requests. Please add any other supporting medical information.

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: 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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