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
Lyfgenia™ (lovotibeglogene autotemce)
HCPCS CODE: J3394

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This form is to be used by participating physicians to obtain coverage for Lyfgenia. 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	☐ Lyfgenia	**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 of therapy *Date when patient started therapy:* _____
2. Please provide the NPI number for the place of administration: _____
3. Please specify the location of administration (e.g. name of facility): _____

4. **Initiation AND Continuation of therapy:**
   a. What is the patient's diagnosis?
      ☐ Sickle cell disease (SCD)
      ☐ β-thalassemia
      ☐ Other – *please specify diagnosis:* _____

   b. Does the patient have a genetic test confirming sickle cell disease? ***(Please attach any tests confirming diagnosis)***
      ☐ Yes ☐ No

   c. How many vaso-occlusive crises has the patient experienced in the past 24 months? ☐ <4 ☐ ≤4

   d. Has the patient tried and failed or has a contraindication or intolerance to hydroxyurea?
      ☐ Yes ☐ No, please explain: _____

   e. Has the patient received or being considered for any other gene therapy treatments?
      ☐ Yes, please explain: _____ ☐ No

   f. Does the patient have any of the following:
      ☐ Positive presence of HIV-1 or HIV-2, hepatitis B, or hepatitis C
      ☐ Inadequate bone marrow function, as defined by an absolute neutrophil count of less than 1000/µL or less than 500/µL for patient taking hydroxyurea or a platelet count less than 120,000/µL without hypersplenism
      ☐ Prior treatment with an allogenic stem cell transplant
      ☐ Prior or current malignancy or immunodeficiency disorder
      ☐ Advanced liver disease defined as alanine transferase greater than 3 times the upper limit of normal, total bilirubin greater than 2 times the upper limit of normal, or baseline prothrombin time 1.5 times the upper limit of normal
      ☐ Other: _____
      ☐ None of the above

   g. Has the patient received prior or being considered to receive gene therapy treatments for sickle cell disease?
      ☐ Yes, please explain: _____ ☐ No

5. Has the patient has experienced an intolerance, contraindication, or adverse event for the requested indication to Casgevy? Please provide date and type of intolerance patient has had. ☐ Yes, please explain: _____ ☐ No

6. **Continuation of therapy -** *Please include rationale for continuation of therapy*_____

7. *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**