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
Roctavian (valoctocogene roxaparvovec)
HCPCS CODE: J1412

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This form is to be used by participating physicians to obtain coverage for Roctavian. 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 ☐ Roctvian	**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 start 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. Has the clinical outcome information been provided within the Audaire Health provider portal as requested by BCBSM?
   ☐ Yes ☐ No Comment _____

5. **Initiation AND Continuation of therapy:**
   a. Is the patient diagnosed with hemophilia A WITH factor VIII deficiency? ☐ Yes ☐ No, please specify: _____
      i. Please indicate how the patient's hemophilia is classified:
      ☐ Mild hemophilia (factor VIII level of 6% - 40%)
      ☐ Moderate hemophilia (factor VIII level of 1% - 5%)
      ☐ Severe hemophilia (factor VIII level < 1%)
      ☐ Unknown
   b. Does the patient have pre-existing immunity to adeno-associated virus serotype 5 (AAV5) capsid? ☐ Yes ☐ No
   c. Does the patient have a history of inhibitors to factor VIII or a positive factor VIII inhibitor screen prior to administration of Roctavian?
      ☐ Yes, please specify level: _____ ☐ No
   d. Has the patient been treated with or exposed to factor VIII concentrates or cryoprecipitate for a minimum of 150 exposure day?
      ☐ Yes ☐ No
   e. Has the patient experienced treatment failure with Hemlibra in the past 6 months?
      ☐ No, please specify: _____
      ☐ Yes, please provide patient's response to Hemlibra below:
      ☐ Spontaneous soft tissue bleeding event
      ☐ Micro-bleeding into a joint
      ☐ Ongoing joint pain of a known target joint
      ☐ Other: _____
   f. Has the patient been treated with any gene therapy or being considered for treatment with gene therapy for hemophilia A?
      ☐ Yes ☐ No
   g. Is Roctavian being dispensed by a treatment center associated with hemophilia that provides high quality hemophilia care with outcome-based results (ie: hemophilia treatment center)? ☐ Yes ☐ 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**

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