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
Skysona® (elivaldogene autotemcel)
HCPCS CODE: J3490/J3590

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This form is to be used by participating physicians to obtain coverage for Skysona. 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	☐ Skysona	**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 for initiation or continuation of therapy?
   ☐ Initiation ☐ Continuation *Date 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. 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. What is the patient's diagnosis?
      ☐ Early active cerebral adrenoleukodystrophy (CALD)
      ☐ Other – *please specify diagnosis:* _____
   b. Genetic testing to confirm diagnosis of adrenoleukodystrophy: _____ (Please attach any tests confirming diagnosis)
   c. Does the patient have a MRI confirming cerebral involvement with abnormal demyelination in cerebral white matter? (Please attach MRI test)
      ☐ Yes ☐ No ☐ Unknown
   d. What is the patient's cerebral adrenoleukodystrophy-specific neurologic function scale?
      ☐ 0 ☐ 1 ☐ Unknown ☐ Other, What is the score? _____
   e. What is the patient's Loes score? Please specify: _____
   f. Does the patient have elevated plasma very long chain fatty acids (VLCFA)?
      ☐ Yes, Please specify: _____ ☐ No ☐ Unknown
   g. Does the patient have any of the following?
      ☐ A prior hematopoietic stem cell transplant (HSCT)
      ☐ Currently eligible for a HSCT with an HLA matched family donor
      ☐ Presence of HIV-1 or HIV-2 infection
      ☐ Presence of Hepatitis B
      ☐ Presence of Hepatitis C
      ☐ Presence of human T lymphotrophic virus 1 (HTLV 1) infection
      ☐ Advanced liver disease is defined as:
         ☐ Aspartate transaminase (AST) greater than 2.5 times the upper limit of normal (ULN)
         ☐ Alanine transaminase (ALT) greater than 2.5 times the ULN
         ☐ Total bilirubin greater than 3.0 mg/dL
      ☐ None of the above

   h. Has the patient received prior treatment with any gene therapy, or is being considered for treatment with any other gene therapy for cerebral adrenoleukodystrophy (CALD)? ☐ Yes ☐ No Comment: _____

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**