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
Soliris® (eculizumab) HCPCS CODE: J1299

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This form is to be used by participating physicians to obtain coverage for Soliris. 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	**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 ***Date patient started therapy***: _____
2. Site of administration? ☐ Provider office/Home infusion ☐ Other: _____
   ☐ Hospital outpatient facility (go to #3) *Reason for Hospital Outpatient administration:* _____
3. Please specify location of administration if hospital outpatient infusion: _____
4. Please provide the NPI number for the place of administration: _____
5. **Initiation AND Continuation of therapy:**
   a. Will the patient be receiving Soliris concurrently with Ultomiris, Uplizna, Enspryng, Empaveli, immunoglobin therapy (IVIG) or other medications to treat any of the diagnoses below?
      ☐ Yes ☐ No Comment: _____
   b. Please check the patient's diagnosis: ☐ Atypical hemolytic uremic syndrome (aHUS) ☐ Paroxysmal nocturnal hemoglobinuria (PNH) ☐ Neuromyelitis optica spectrum disorder (NMOSD) ☐ Refractory generalized myasthenia gravis (gMG) ☐ Other _____
   c. For **PNH**:
      i. Does the patient have flow cytometric confirmation of PNH type III red cells? ☐ Yes, Please provide laboratory report for review: _____, Date: _____ ☐ No
      ii. How many transfusions has the patient had in the previous 24 months (prior to Soliris)? _____
      iii. Has the patient experienced a major adverse thrombotic vascular event from thromboembolism? ☐ Yes, List event: _____ ☐ No
      iv. What is the patient's lactic dehydrogenase (LDH) level? _____Units/L Date: _____ Lab's reference range: _____
      v. Which of these symptoms does the patient experience? ☐ Weakness ☐ Fatigue ☐ Hemoglobinuria ☐ Abdominal pain ☐ Dyspnea ☐ Hemoglobin < 10 g/dL ☐ A major vascular event ☐ Dysphagia ☐ Erectile dysfunction ☐ Other _____
   d. For **aHUS:**
      i. Have common causes of typical hemolytic uremic syndrome been ruled out, including infectious causes of HUS and thrombotic thrombocytopenic purpura (TTP)? ☐ Yes ☐ No, Comment: _____
      ii. What is the hemoglobin level prior to initiation of treatment? _____g/dL Date: _____
      iii. What is the platelet count prior to initiation of treatment? _____/mm³ Date: _____
      iv. Does the patient have evidence of hemolysis? ☐ Yes ☐ No Comment: _____
         1. If yes, what is the patient's lactic dehydrogenase (LDH) level? _____Units/L Date: _____
         2. If yes, what is the patient's haptoglobin level? _____mg/dL Date: _____
         3. If yes, does the patient have schistocytosis? ☐ Yes ☐ No Comment: _____
      v. What is the patient's serum creatinine? _____mg/dL Date: _____
      vi. Is the patient currently undergoing dialysis? ☐ Yes ☐ No Comment: _____
   e. For refractory **gMG**:
      i. How has the patient been diagnosed with gMG? ***(Please attach any tests confirming diagnosis)*** ☐ Anti-AChR antibody test ☐ Edrophonium test ☐ Clinical response to oral cholinesterase inhibitors (ex. pyridostigmine) ☐ Repetitive nerve stimulation (RNS) ☐ Single-fiber electromyography (SFEMG) ☐ Other:_____
      ii. Does the patient have a history of thymectomy within 12 months, current thymoma, or other neoplasms of the thymus? ☐ Yes, Date: _____ ☐ No
      iii. What is the severity of the patient's MG? ☐ Class I ☐ Class II ☐ Class III ☐ Class IV ☐ Class V
      iv. Has the patient tried and failed therapy with at least one conventional therapy?
         ☐ Methotrexate Date started: _____ Date ended: _____
         ☐ Azathioprine Date started: _____ Date ended: _____
         ☐ Cyclophosphamide Date started: _____ Date ended: _____
         ☐ Cyclosporine Date started: _____ Date ended: _____
         ☐ Mycophenolate mofetil Date started: _____ Date ended: _____
         ☐ Tacrolimus Date started: _____ Date ended: _____
         ☐ Other: _____, Date started: _____ Date ended: _____
      v. Has the patient tried and failed Vyvgart? ☐ Yes ☐ No Comment _____
      vi. Is the patient currently receiving and will continue to receive a standard of care regimen for their diagnosis with Soliris? ☐ Yes ☐ No Comment: _____
   f. For NMOSD:
      i. Is the patient aquaporin-4 (AQP4) antibody positive? ☐ Yes ☐ No Comment: _____
      ii. Has the patient tried and failed rituximab/rituximab biosimilars, Uplizna, and Enspryng?
         ☐ Yes, Please list: _____ ☐ No Comment _____
6. **Continuation request:** Soliris start date _____
   a. Has the patient's condition improved while on therapy with Soliris? ☐ Yes ☐ No Comment _____

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 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**

1/6/2020; 12/3/2020; 6/10/2021; 6/9/2022; 10/5/2022