

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 (availability.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.

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Blue Cross Blue Shield/Blue Care Network of Michigan
Medication Authorization Request Form
Ultomiris™ (ravulizumab intravenous infusion) HCPCS CODE: J1303



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This form is to be used by participating physicians to obtain coverage for Ultomiris. 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: _____
Please provide the NPI number for the place of administration: _____
4. Will the patient receive the first loading dose under the guidance of a health care provider prior to subcutaneous self-administered formulation? ☐ Yes ☐ No **Comment:** _____
5. **Initiation AND Continuation of therapy:**
 - a. Will the patient be receiving Ultomiris concurrently with Soliris, Empaveli, immunoglobulin therapy (IVIG), or other medications to treat any of the diagnoses below?
☐ yes ☐ no **Comment:** _____
 - b. Please check the patient's diagnosis:
☐ Paroxysmal nocturnal hemoglobinuria (PNH) ☐ Atypical hemolytic uremic syndrome (aHUS) ☐ 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 Ultomiris)? _____
 - iii. Has the patient experienced a major adverse thrombotic vascular event from thromboembolism?
☐ Yes, List event: _____ ☐ No **Comment:** _____
 - iv. What is the patient's lactic dehydrogenase (LDH) level? _____ Units/L Lab range: _____ Date: _____
 - 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 rule 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 Lab range: _____ 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 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 Ultomiris? ☐ Yes ☐ No **Comment:** _____
6. **Continuation request:** Ultomiris start date _____
 - a. Has the patient's condition improved while on therapy with Ultomiris? ☐ 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

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