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 October 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 and Pharmacy Benefit Drug Prior Auth* 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 **authorizations.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 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 Prior Auth portal overview mini module*.

For detailed information about accessing the Provider Training site, see the "Online training" section of the Training Tools page on **authorizations.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
### Aflibercept Products
**Eylea® (aflibercept): J0178, Eylea HD (aflibercept): J0177, Ahzantive: Q5150, Opuviz: J3590, Yesafili: J3590**

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This form is to be used by participating physicians to obtain coverage for Eylea and Eylea HD. 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. Please provide the NPI number for the place of administration: _____

3. **Initiation AND Continuation of therapy:**
   a. What eye(s) will be treated? ☐ Left eye ☐ Right eye

   b. What is the patient's dose and frequency of requested medication?
   Initiation - Dose: _____mg Frequency: ☐ 4 weeks ☐ 6 weeks ☐ 8 weeks ☐ Other: _____
   Maintenance - Dose: _____mg Frequency every: ☐ 4 weeks ☐ 6 weeks ☐ 8 weeks ☐ Other: _____

   c. What is the patient's diagnosis?
   ☐ Neovascular (wet) age-related macular degeneration (AMD) ☐ Diabetic retinopathy (DR) ☐ Retinopathy of Prematurity (ROP- go to f)
   ☐ Macular edema due to retinal vein occlusion (RVO) ☐ Other, Please specify: _____
   ☐ Diabetic macular edema (DME)
      a. What is the visual acuity in the right eye? _____
      b. What is the visual acuity in the left eye? _____

   d. Has the patient tried Avastin or bevacizumab biosimilar intravitreal treatment?
   ☐ No
   ☐ Yes
      i. Which eye was treated? ☐ Left eye ☐ Right eye
      ii. Please enter number of Avastin or a bevacizumab biosimilar injections patient has received and in which eye? _____
      iii. What was the patient's frequency of Avastin or bevacizumab biosimilar? ☐ 4 weeks ☐ 6 weeks ☐ 8 weeks ☐ Other: _____
      iv. Date of the last three Avastin or a bevacizumab biosimilar injection: _____
      v. What was the patient's outcome while on Avastin or bevacizumab biosimilar therapy?
      ☐ Visual acuity improvement ☐ Reduction in edema ☐ Decrease in retinal thickness ☐ Condition remained the same
      ☐ Worsening in visual acuity ☐ Increased edema ☐ Increase in retinal thickness ☐ Persistent edema
      ☐ Intolerance to the medication: _____
      ☐ Other, Please list: _____

   e. Has the patient failed treatment with other anti–VEGF therapy? ☐ Yes ☐ No
      i. If yes, List what treatment(s) patient failed: _____

   f. Diagnosis of retinopathy of prematurity (ROP) only
      i. What is the patient's gestational age (weeks)? _____
      ii. What is the patient's birth weight (kg)?_____
      iii. What is the patient's current weight(kg)? _____
      iv. What is the patient's ROP classified as?
      ☐ ROP Zone I Stage 1+, 2+, 3 or 3+ ☐ ROP Zone II Stage 2+ or 3+
      ☐ Aggressive posterior ROP ☐ Other

4. **Continuation of therapy:**
   a. How has the patient's condition changed while on therapy?
   ☐ Improved; Please describe: _____
   ☐ Stable; Please describe: _____
   ☐ Worsened; Please describe: _____
   ☐ Other; Please describe: _____

***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<br>☐ Attached chart notes | ☐ Pertinent test 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** |