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
Nucala® (mepolizumab) HCPCS CODE: J2182

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This form is to be used by participating physicians to obtain coverage for Nucala®. 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. How is this medication being administered? ☐ Self-administered ***(Please fax this completed form to BCBSM at (866) 601-4425)*** ☐ Health Care Professional administered (Continue to #3)
3. Please provide reason(s) why the patient needs to have Nucala administered by a healthcare professional:
   ☐ Patient has co-morbidities or chronic medical conditions (such as: rheumatoid arthritis, Parkinson's disease)
   ☐ Other: _____
4. Site of administration? ☐ Provider office/Home infusion ☐ Other: _____
   ☐ Hospital outpatient facility (go to #4) *Reason for Hospital Outpatient administration:* _____
5. **Please specify location of administration if hospital outpatient infusion:** _____
6. **Please provide the NPI number for the place of administration:** _____
7. **Initiation AND Continuation of therapy:**
   a. Will the patient be using Nucala in combination with other biologic agents (for example: Xolair, Fasenra, Cinqair or Duxipent) or targeted DMARD medications?
      ☐ yes ☐ no Comment: _____
   b. Is the patient currently receiving and will continue to receive a standard of care regimen for their diagnosis with Nucala? ☐ Yes ☐ No Comment: _____
   c. Please check the patient's diagnosis: ☐ Severe eosinophilic asthma (**EA, go to d and e**)
      ☐ Hypereosinophilic syndrome (**HES go to d then h to j**)
      ☐ Eosinophilic granulomatosis with polyangiitis (**EGPA, go to f and g**)
      ☐ Chronic rhinosinusitis with nasal polyps (**CRSwNP, go to k**)
      ☐ Other: _____
   d. **EA and HES:** What is the patient's blood eosinophil level at initiation of treatment, in cells/microliter?: _____ cells/microliter Date: _____
   e. **EA:** Which treatment(s) did not adequately control the patient's severe eosinophilic asthma symptoms after a trial of at least 3 months?
      ☐ Systemic corticosteroid: _____ Date: *Start:* _____ *End:* _____
      ☐ High dose inhaled corticosteroids: _____ Date: *Start:* _____ *End:* _____
      ☐ Long acting beta2-agonist: _____ Date: *Start:* _____ *End:* _____
      ☐ Leukotriene receptor antagonist: _____ Date: *Start:* _____ *End:* _____
      ☐ Combination asthma inhaler with a HIGH dose corticosteroid and a long acting beta agonist: _____ Date: *Start:* _____ *End:* _____
      ☐ Combination asthma inhaler with a MEDIUM dose corticosteroid and a long acting beta agonist: _____ Date: *Start:* _____ *End:* _____
      ☐ Long acting muscarinic antagonist (LAMA): _____ Date: *Start:* _____ *End:* _____
      ☐ Other: _____ Date: *Start:* _____ *End:* _____
   f. **EPGA:** Does the patient currently have asthma or have a history of asthma? ☐ yes ☐ no Comment: _____
   g. **EPGA:** How was the patient diagnosed with eosinophilic granulomatosis with polyangiitis (EGPA)?
      ☐ Histopathological evidence of eosinophilic vasculitis, perivascular eosinophilic infiltration, or eosinophil-rich granulomatous inflammation
      ☐ Neuropathy ☐ Pulmonary infiltrates ☐ Allergic rhinitis and nasal polyps ☐ Cardiomyopathy ☐ Glomerulonephritis
      ☐ Alveolar hemorrhage ☐ Palpable purpura ☐ Antineutrophil cytoplasmic antibody (ANCA) positivity ☐ Other: _____ ☐ None
   h. **HES:** How many hypereosinophilic syndrome (HES) flares has the patient had within the past 12 months (defined as documented HES-related worsening of clinical symptoms or blood eosinophil counts requiring an escalation in therapy)? _____
   i. **HES:** Has the patient been stable on hypereosinophilic syndrome (HES) therapy for at least 4 weeks? (for example: oral corticosteroids, immunosuppressive or cytotoxic therapy).
      ☐ Yes ☐ No Comment: _____
   j. **HES:** Does the patient have eosinophilia of unknown clinical significance, non-hematologic secondary HES (for example: drug hypersensitivity, parasitic helminth infection, HIV infection, non-hematologic malignancy), or FIP1L1-PDGFRα kinase-positive HES?
      ☐ Yes ☐ No Comment: _____
   k. **CRSwNP:** Has the patient tried and failed intranasal corticosteroids (for example: Flonase)? ☐ Yes ☐ No Comment: _____
8. **Continuation request:** (please answer above questions as well): **Nucala start date**: _____
   a. Have the patient's signs and symptoms improved with Nucala? ☐ Yes ☐ No, Comment: _____ ☐ Other:_____

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 ☐ Attach Chart Notes	☐ Attach Diagnostic Tests
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**

11/6/2015; 2/25/2016; 2/2/2018; 10/11/2018; 1/31/2020; 3/17/2020; 12/3/2021; 10/7/2021; 10/6/2022, 04/01/2024