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
Reblozyl® (luspatercept–aamt) HCPCS CODE: J0896

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This form is to be used by participating physicians to obtain coverage for Reblozyl. 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 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. Please check the patient's diagnosis**:** ☐ Beta thalassemia ☐ Myelodysplastic syndrome (MDS) ☐ Other: _____
   b. **Beta thalassemia:**
      i. How was the patient diagnosed with beta thalassemia? ***(Please attach any tests confirming diagnosis)***
         ☐ Genetic testing: _____ ☐ Other: _____
      ii. Does the patient have Hemoglobin S/β-thalassemia or α-thalassemia?
         ☐ Yes ☐ No Comment _____
      iii. Is the patient considered transfusion dependent with a history of at least 100 mL/kg/year of pRBCs in the previous two years?
         ☐ Yes ☐ No Comment _____
      iv. Is the patient managed under standard thalassemia guidelines with ≥ 8 transfusions of pRBCs per year in the previous two years?
         ☐ Yes ☐ no Comment: _____
   c. **Myelodysplastic syndrome (MDS):**
      i. Does the patient have anemia requiring at least 2 units of red blood cells over 8 weeks? ☐ Yes ☐ No
      ii. Please select the patient's World Health Organization (WHO)/French American British (FAB) with IPSS-R classification for MDS:
         ☐ Very low risk ☐ Low risk ☐ Intermediate risk ☐ High risk
      iii. Does the patient have ring sideroblast ≥ 15% of erythroid precursors in bone marrow OR ≥ 5% if the SF3B1 mutation is present? ☐ Yes ☐ No
      iv. Does the patient have less than 5% blasts in the bone marrow? ☐ Yes ☐ No
      v. Has the patient used erythropoietin or darbepoetin alpha? ☐ Yes ☐ No
         1. Provide the product name, dose, frequency, and length of therapy: _____
            a. What was the response to the treatment?
               ☐ Never responded ☐ Lost response ☐ Intolerance to treatment ☐ Adverse event ☐ Other: _____
         2. What is the patient's endogenous serum erythropoietin level in U/L? _____
      vi. Has the patient used any prior therapy with disease-modifying agents for underlying MDS disease (examples: immune-modulatory drug, hypomethylating agents, or immunosuppressive therapy)? ☐ Yes, Please provide the name of the drug: _____ ☐ No
      vii. Does the patient have MDS associated with del 5q cytogenetic abnormality? ☐ Yes ☐ No
      viii. Does the patient have secondary MDS known to have arisen as the result of chemical injury or treatment with chemotherapy and/or radiation for other diseases?
         ☐ Yes ☐ No
6. **Continuation request: Reblozyl start date**: _____
   ☐ Reduction in transfusions for transfusion dependent patients
   ☐ Increase in hemoglobin with non- transfusions patients
   ☐ Other: _____
   ☐ None
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 ☐ Attach Chart Notes	☐ Attach Diagnostic Tests and Labs
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**

1/31/2020; 7/1/2020; 10/1/2020; 8/12/202; 10/7/2022