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
## Signifor® LAR (pasireotide) HCPCS CODE: J2502

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This form is to be used by participating physicians to obtain coverage for Signifor LAR. 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<br>**Pt weight (in kg)** **Date recorded:**_____ | **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 medication being administered by: ☐ Self (patient) ☐ Health care professional (physician/nurse)
2. Is the patient being seen by an Endocrinologist? ☐ yes ☐ no Specialty: _____
3. What is the patient's dose and frequency of requested therapy? _____
4. Is this request for: ☐ Initiation ☐ Continuation ***Original start date:*** _____
5. **Initiation AND Continuation of therapy:**
   a. Please check the patient's diagnosis: ☐ Acromegaly ☐ Cushings Disease
      ☐ Hormone secreting tumors of the GI tract ☐ Other: _____
   b. Has the patient had a poor response to surgery and/or is surgery not an option for them?
      ☐ yes ☐ no; Please explain: _____
   c. Does the patient have elevated insulin-like growth factor-1 (IGF-1)? *(Before treatment started)*
      ☐ yes, current level _____, date drawn: _____ ☐ no
   d. Please check which medications the patient has tried:
      ☐ Somatuline Depot ☐ Sandostatin
      ☐ Sandostatin LAR ☐ Somavert ☐ Other: _____
6. **Continuation request:** Signifor LAR start date: _____
   a. Has the patient had improvement in manifestations of acromegaly?
      ☐ yes ☐ no; Please explain: _____
   b. If the patient has improvement in manifestations of acromegaly, please check which apply:
      ☐ Decrease in Growth Hormone (GH) and/or IGF-1 levels
      ☐ Decrease in pituitary tumor size
      ☐ Other, explain: _____
7. Please attach any chart notes or additional documentation and submit to plan. ***(Required)***

**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 | ☐ Patient and Physician Information complete |
| **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** |



9/22/2015; 11/20/2015; 2/2/2018;10/11/2018