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
Xolair® (omalizumab) HCPCS CODE: J2357

Blue Cross Blue Shield Blue Care Network of Michigan

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This form is to be used by participating physicians to obtain coverage for Xolair®. 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 **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 for Initiation or Continuation of therapy? ☐ 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)***
   ☐ Healthcare professional administered ***(Continue to #3)***

3. Will the patient receive the first 3 doses under the guidance of a health care provider? ☐ Yes ☐ No Comment: _____

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 Xolair in combination with other biologic agents (for example: Nucala, Fasenra, Cinqair or Dupixent) or targeted DMARD medications?
      ☐ Yes ☐ No Comment _____

   b. **Please check the patient's diagnosis:** ☐ Moderate to Severe Allergic Asthma (AA, *go to c then d)* ☐ Nasal polyps (go to c then i)
      ☐ Chronic idiopathic urticaria *(CIU, go to f)* ☐ IgE-mediated food allergy (go to c, then k) ☐ Other _____

   c. What is the patient's IgE level at the start of therapy? _____IU/mL_ Date: _____

   d. **AA:** Which of the following tests did the patient receive for the diagnosis of moderate to severe allergic asthma?
      ☐ Positive skin test to a perennial aeroallergen (allergens with year-round exposure which may include molds, dust mites, cock roaches, animal feathers or dander, etc.)
      ☐ In-vitro reactivity to a perennial aeroallergen (allergens with year-round exposure which may include molds, dust mites, cock roaches, animal feathers or dander, etc.)
      ☐ N/A ☐ Other: _____

   e. **AA:** Which treatment(s) did not adequately control the patient's severe allergic 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. **Chronic Idiopathic Urticaria (CIU):** How long has the patient been experiencing hives and itching (occurring daily or almost daily) in weeks?
      ☐ ≥ 6 weeks ☐ < 6 weeks ☐ Other: _____

   g. **CIU:** Have other diagnoses (such as Atopic Dermatitis, Contact Dermatitis, and reversible triggers) been ruled out?
      ☐ Yes ☐ No Comment: _____

2/4/2021; 10/7/2021; 10/6/2022, 04/01/2024, 05/01/2024

h. **CIU:** Which medications did the patient try and experience treatment failure at maximally tolerated doses for at least 2 months?
- ☐ 1st Generation Antihistamine drug and dose (such as Benadryl): _____ ***Start:*** _____ ***End:*** _____
- ☐ 2nd Generation Antihistamine drug and dose (such as: Zyrtec, Claritin, Allegra): _____ ***Start:*** _____ ***End:*** _____
- ☐ H2 antagonist drug and dose (such as: Zantac or Pepcid): _____ ***Start:*** _____ ***End:*** _____
- ☐ Leukotriene receptor antagonist (such as: Singulair): _____ ***Start:*** _____ ***End:*** _____
- ☐ Hydroxyzine ***Start:*** _____ ***End:*** _____
- ☐ Doxepin ***Start:*** _____ ***End:*** _____
- ☐ Other: _____

i. **Nasal polyps:** Is the patient currently receiving and will continue to receive a standard of care regimen for their diagnosis with Xolair?
☐ Yes ☐ No Comment: _____

j. **Nasal polyps:** Has the patient tried and failed intranasal corticosteroids?
☐ Yes ☐ No Comment: _____

k. **IgE-mediated food allergy:** Do the patient have a history of an allergic reaction following the consumption of peanuts, milk, eggs, wheat, cashews, hazelnuts or walnuts?
☐ Yes, please specify: _____ ☐ No Comment: _____

l. **IgE-mediated food allergy:** Does the patient have a food allergy been confirmed by either:
- ☐ IgE specific antibodies, please specify IgE level (kUA/L): _____
- ☐ Food-specific skin prick test (SPT)

m. **IgE-mediated food allergy:** Will the patient be on allergen avoidant diet while on Xolair?
☐ Yes ☐ No Comment: _____

n. **IgE-mediated food allergy:** Does the patient have an active prescription and access to an epinephrine auto-injector?
☐ Yes ☐ No Comment: _____

o. **IgE-mediated food allergy:** Will the patient be on any other food allergy desensitization treatments?
☐ Yes ☐ No Comment: _____

8. **Continuation request** (please answer above questions as well): **Xolair start date:** _____

a. Have the patient's signs and symptoms improved with Xolair?
☐ Yes ☐ No, Comment: _____ ☐ Other: _____

b. Please provide reason(s) why the patient needs to continue to have Xolair administered by a healthcare professional:
- ☐ Prior history of anaphylaxis including to Xolair, or other agents such as foods, drugs, or biologics
- ☐ Hypersensitivity reactions during the first 3 doses under the guidance of a healthcare provider
- ☐ Patient or caregivers who have been trained and are unable to recognize or treat symptoms of anaphylaxis
- ☐ Patient has co-morbidities or chronic medical conditions (such as: rheumatoid arthritis, Parkinson's disease), please specify:_____
- ☐ 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 ☐ Attached 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**