

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 (availability.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
Zynteglo® (betibeglogene autotemcel)
HCPCS CODE: J3393



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This form is to be used by participating physicians to obtain coverage for Zynteglo. 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 ☐ Zolgensma	Phone/Fax: P: () - F: () -
Dose and Quantity	NPI
Directions	Contact Person
Date of Service(s)	Contact Person Phone / Ext.

STEP 1: DISEASE STATE INFORMATION

- Has patient previously received Zynteglo or other gene therapy? ☐ Yes ☐ No Comment: _____
- Please provide the NPI number for the place of administration: _____
- Please specify the location of administration (e.g. name of facility): _____
- Does the physician attest to providing clinical outcome information within the appropriate provider portal as requested by BCBSM?
☐ Yes ☐ No Comment: _____
- Initiation AND Continuation of therapy:**
 - What is the patient's diagnosis?
☐ β -thalassemia who require regular red blood cell (RBC) transfusions
☐ Other – *please specify diagnosis:* _____
 - How was the patient diagnosed with β -thalassemia? (*Please attach any tests confirming diagnosis*)
☐ Genetic testing: _____ ☐ Other: _____
 - Does the patient have Hemoglobin S/ β -thalassemia or α -thalassemia?
☐ Yes ☐ No Comment: _____
 - 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: _____
 - Is the patient managed under standard thalassemia guidelines with ≥ 8 transfusions of pRBCs per year in the previous two years?
☐ Yes ☐ no Comment: _____
 - Does the patient have any of the following?
☐ A prior hematopoietic stem cell transplant (HSCT) or currently be eligible for a HSCT with a willing and able HLA matched donor as determined by a hematologist and/or stem cell transplant specialist
☐ Presence of HIV-1 or HIV-2 infection
☐ Any prior malignancy with the exception of adequately treated cone-biopsied in situ carcinoma of the cervix uteri and basal or squamous cell carcinoma of the skin
☐ Myeloproliferative or significant immunodeficiency disorder unless patients meet any of the following:
☐ Vaccinated against hepatitis B (hepatitis B surface antibody-positive) and negative for other markers of prior hepatitis B infection
☐ Had past exposure to HBV but were negative by assessment for HBV DNA
☐ Are positive for anti-hepatitis C antibodies and have negative HCV viral load
☐ Uncorrected bleeding disorder
☐ Advanced liver disease defined AS:
☐ Alanine transferases or direct bilirubin greater than 3 times the upper limit of normal (ULN)
☐ Baseline prothrombin time or partial thromboplastin time greater than 1.5 times the ULN suspected of arising from liver disease
☐ Magnetic resonance imaging (MRI) of the liver demonstrating clear evidence of cirrhosis
 - Has the patient received prior treatment with any gene therapy or is being considered for treatment with any other gene therapy for beta-thalassemia?
☐ Yes ☐ No Comment: _____
- Continuation of therapy** - Please include rationale for continuation of therapy _____
- 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 necessary chart notes	☐ Important laboratory 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

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