Michigan Prior Authorization Request Form
For Prescription Drugs

Instructions

Important: Please read all instructions below before completing FIS 2288.

Section 2212c of Public Act 218 of 1956, MCL 500.2212c, requires the use of a standard prior authorization form when a policy, certificate or contract requires prior authorization for prescription drug benefits.

A standard form, FIS 2288, is being made available to simplify exchanges of information between prescribers and health insurers as part of the process of requesting prescription drug prior authorization. This form will be updated periodically and the form number and most recent revision date are displayed in the top left hand corner.

- Prior authorization requests are defined as requests for pre-approval from an insurer for specified medications or quantities of medications before they are dispensed.
- Prescriber means the term as defined in section 17708 of the Public Health Code, 1978 PA 368, MCL 333.17708.
- Prescription drug means the term as defined in section 17708 of the Public Health Code, 1978 PA 368, MCL 333.17708.
- This form is made available for use by prescribers to initiate a prior authorization request.
- Insurers may request additional information or clarification needed to process a prior authorization request. The prior authorization is not considered granted if the prescriber fails to submit the additional information within 72 hours after the date and time of the original submission of a properly completed prior authorization request.
- In order to designate a prior authorization request for expedited review, a prescriber must certify that applying the 15-day standard review period may seriously jeopardize the life and health of the patient or the patient’s ability to regain maximum function.
Michigan Prior Authorization
Request Form for Prescription Drugs  Fax: 858-790-7100

☐ Expedited Review Request: I hereby certify that a standard review period may seriously jeopardize the life or health of the patient or the patient’s ability to regain maximum function.
Physician’s Direct Contact Phone Number (   ) _______ - _______ Initials: ______________

A) Reason for Request
☐ Initial Authorization Request  ☐ Renewal Request  ☐ DAW

B) Patient Demographics
Is patient hospitalized:  ☐ Yes  ☐ No
Patient Name: ________________________________ DOB: ____________________
Patient Health Plan ID: ____________________________________________
☐ Male  ☐ Female

C) Pharmacy Insurance Plan
☐ Priority  ☐ Magellan  ☐ Blue Cross Blue Shield of Michigan  ☐ HAP  ☐ ______________
☐ Total Health Care  ☐ Blue Care Network  ☐ HealthPlus of Michigan  ☐ Meridian Health Plan

D) Prescriber Information
Prescriber Name: ____________________________ NPI: _______________ Specialty: _______________
DEA (required for controlled substance requests only): ____________________________
Contact Name: ____________________________ Contact Phone: _____________ Contact Fax: ______________
Health Plan Provider ID (if accessible): ____________________________________________

E) Pharmacy Information (optional)
Pharmacy Name____________________________ Pharmacy Telephone__________________________

F) Requested Prescription Drug Information
Drug Name: ________________________________ Strength: __________________________
Dosing Schedule: __________________________ Duration: __________________________
Diagnosis (specific) with ICD#: __________________________
Place of infusion / injection (if applicable): __________________________
Facility Provider ID / NPI: __________________________________________
Has the patient already started the medication? ______ Yes ______ No If so, when? __________
G) Rationale for Prior Authorization (e.g., information such as history of present illness, past medical history, current medications, etc.; you may also attach chart notes to support your request if you believe they will assist with the review process)

H) Failed/Contraindicated Therapies

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<th>Drug Name</th>
<th>Strength</th>
<th>Dosing Schedule</th>
<th>Duration</th>
<th>Adverse Event/Specific Failure</th>
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I) Other Pertinent Information (Optional - to be filled out if other information is necessary such as relevant diagnostic labs, measures of response to treatment, etc.) Please refer to plan's website for additional information that may be necessary for review. Please note that sending this form with insufficient clinical information may result in extended review period or adverse determination.

I represent to the best of my knowledge and belief that the information provided is true, complete and fully disclosed. A person may be committing insurance fraud if false or deceptive information with the intent to defraud is provided.

Physician's Name: ________________________________

Physician's Signature: __________________________

Date: __________

PA 218 of 1956 as amended requires the use of a standard prior authorization form by prescribers when a patient's health plan requires prior authorization for prescription drug benefits.

*For Health Plan Use Only*

Request Date: ___________________________  LOB: ___________________________

Approved: ___________________________  Denied: ___________________________

Approved By: ___________________________  Denied By: ___________________________

Effective Date: ___________________________  Reason for Denial: ___________________________

Additional Comments: ___________________________
Some of the information needed to make a determination for coverage is not specifically requested on the Michigan Prior Authorization Request Form for Prescription Drugs. To avoid delays in reviewing your request, please make sure to include all of the following information.

1. Is the patient currently taking any of the following medications: amiodarone, carbamazepine, phenytoin, rifampin, rifabutin, rifapentine, bosentan, dexamethasone, modafinil or nafcillin?  
   | Y | N |

2. Is the patient 18 years of age or older?  
   | Y | N |

3. Does the patient have a diagnosis of chronic Hepatitis C, genotype 1 or genotype 3?  
   | Y | N |

4. Is the treatment being prescribed and monitored by a hepatologist?  
   | Y | N |

5. Does the patient have evidence of hepatitis C infection (e.g., at least two detectable HCV RNA levels separated by 6 months), or if the patient has an acute infection, has the patient received monitoring of HCV RNA for at least 6 months, with at least two detectable HCV RNA levels over the past 6 months (separated by 6 months)?  
   | Y | N |

   - **Note:** If the patient has evidence of prescriptions for past treatment for hepatitis C, one detectable HCV RNA level within the last 6 months is acceptable.

6. Has the patient been evaluated to be absent of current alcohol and other substance abuse, and appropriately advised/cautioned of continuing these activities?  
   | Y | N |

7. Does the patient have genotype 3 infection?  
   | Y | N |

8. Has the patient had a previous trial of Sovaldi triple therapy (Sovaldi/peginterferon/ribavirin) for 12 weeks?  
   | Y | N |

9. Does the patient have a contraindication to interferon (for example, concurrent diagnosis of autoimmune hepatitis or other autoimmune disorder; a known hypersensitivity reaction such as urticaria, angioedema, bronchoconstriction and anaphylaxis to alpha interferons, PEG, or any component of peginterferon; documented depression; decompensated hepatic disease; a baseline neutrophil count below 1,500 per microliter, a baseline platelet count below 90,000, or a baseline hemoglobin below 10g/dL that has not responded to treatment)?  
   | Y | N |

10. Does the patient have cirrhosis or is post-liver transplant?  
    | Y | N |

11. Does the patient have genotype 1 infection?  
    | Y | N |

12. Has the patient had a previous trial of Harvoni?  
    | Y | N |

13. Is this a post-liver transplant patient?  
    | Y | N |

14. Does the patient have cirrhosis?  
    | Y | N |

15. Does the patient have compensated cirrhosis (Child-Pugh A)?  
    | Y | N |

16. Is the patient using Daklinza in combination with Sovaldi (sofosbuvir)?  
    | Y | N |

17. Does the patient have decompensated cirrhosis or is post-liver transplant?  
    | Y | N |

18. Is the patient using a regimen of Daklinza and Sovaldi (sofosbuvir) WITH ribavirin?  
    | Y | N |

19. Is the patient using a medication that contains efavirenz (Atripla or Sustiva) or etravirine (Intelen) while taking Daklinza in combination with Sovaldi (sofosbuvir)?  
    | Y | N |