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

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Strength</th>
<th>Dosing Schedule</th>
<th>Duration</th>
<th>Adverse Event/Specific Failure</th>
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</thead>
<tbody>
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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”

<table>
<thead>
<tr>
<th>Request Date:</th>
<th>LOB:</th>
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<tbody>
<tr>
<td>Approved:</td>
<td>Denied:</td>
</tr>
<tr>
<td>Approved By:</td>
<td>Denied By:</td>
</tr>
<tr>
<td>Effective Date:</td>
<td>Reason for Denial:</td>
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<td>Additional Comments:</td>
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Michigan Department of Insurance and Financial Services

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Visit DIFS online at: www.michigan.gov/difs Phone DIFS toll-free at: 877-999-6442
UNIVERSITY OF MICHIGAN – DAYTRAN (methylphenidate patch)

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.

**For all patients, please answer questions 1-6**

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
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<tbody>
<tr>
<td>1. Is the patient between the ages 6 and 17?</td>
<td>Y N</td>
</tr>
<tr>
<td>2. Will the patient be regularly monitored for adverse events, including weight loss and decreased growth velocity for children, contact sensitization, and long-term usefulness?</td>
<td>Y N</td>
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<tr>
<td>3. Does the patient have the diagnosis of ADD/ADHD?</td>
<td>Y N</td>
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<tr>
<td>4. Are the ADHD symptoms causing clinically significant impairment in social, academic, or occupational functioning?</td>
<td>Y N</td>
</tr>
<tr>
<td>5. Has the patient tried and had success with oral methylphenidate products? (confirmation of a patient’s positive response to the medication is required before approval of the patch formulation will be considered)</td>
<td>Y N</td>
</tr>
<tr>
<td>6. Is the prescriber aware of the potential for future systemic allergic reactions to oral methylphenidate products if the patient experiences a contact sensitization with Daytrana?</td>
<td>Y N</td>
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**For patients age 17 and over please answer question 7 and 8.**

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<th>Question</th>
<th>Answer</th>
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<tr>
<td>7. Was the patient stabilized on Daytrana before the age of 17 and has the patient continuously used Daytrana since?</td>
<td>Y N</td>
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<tr>
<td>8. Is the patient diagnosed with ADHD and has another dosage form of methylphenidate been tried and failed by this patient?</td>
<td>Y N</td>
</tr>
</tbody>
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