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 by the Department of Insurance and Financial Services 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.

- This form is made available for use by prescribers to initiate a prior authorization request with the health insurer.
- 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.
- Pursuant to MCL 500.2212c, prescribers and insurers must comply with required timeframes pertaining to the processing of a prior authorization request. Insurers may request additional information or clarification needed to process a prior authorization request.
- The prior authorization is considered granted if the insurer fails to grant the request, deny the request, or require additional information of the prescriber within 72 hours after the date and time of submission of an expedited prior authorization request or within 15 days after the date and time of submission of a standard prior authorization request. If additional information is requested by an insurer, a prior authorization request is considered to have been granted by the insurer if the insurer fails to grant the request, deny the request, or otherwise respond to the request of the prescriber within 72 hours after the date and time of submission of the additional information for an expedited prior authorization request; or within 15 days after the date and time of submission of the additional information for standard prior authorization request.
- The prior authorization is considered void if the prescriber fails to submit the additional information within 5 days after the date and time of the original submission of a properly completed expedited prior authorization request or within 21 days after the date and time of the original submission of a properly completed standard 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.

**PRESCRIBERS PLEASE SUBMIT THIS FORM TO THE PATIENT’S HEALTH PLAN ONLY.** Please do not send to the department.

Only provide the physician’s direct contact number and initials if you are requesting an Expedited Review Request.
Michigan Prior Authorization
Request Form for Prescription Drugs

(PRESCRIBERS SUBMIT THIS FORM TO THE PATIENT’S HEALTH PLAN)

☐ Standard Review Request

☐ 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  ☐ Prescription Drug Plan

☐ 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: ____________________ |                                  |
Dupilumab (Dupixent)

FDA-Approved Indication(s)
- For the treatment of patients aged 12 years and older with moderate-to-severe atopic dermatitis whose disease is not adequately controlled with topical prescription therapies or when those therapies are not advisable.
- As an add-on maintenance treatment in patients with moderate-to-severe asthma aged 12 years and older with an eosinophilic phenotype or with oral corticosteroid (OCS) dependent asthma.
- As an add-on maintenance treatment in adult patients with inadequately controlled chronic rhinosinusitis with nasal polyposis (CRSwNP).

FDA-Recommended Starting Dose
- Atopic Dermatitis (adults): An initial dose of 600 mg, followed by 300 mg every other week
- Atopic Dermatitis (adolescents):
  - Less than 60 kg: 400 mg (two 200 mg injections), followed by 200 mg every other week
  - More than 60 kg: 600 mg (two 300 mg injections), followed by 300 mg every other week
- Asthma: An initial dose of 400 mg or 600 mg, followed by 200 mg or 300 mg every other week
- CRSwNP: 300 mg every other week

How Supplied
- 200 mg/1.14 mL and 300 mg/2 mL pre-filled syringes in 2-count packages

Coverage Criteria
For initial review:
- Atopic Dermatitis:
  - The member has a diagnosis of moderate-to-severe atopic dermatitis, \textit{AND}
  - The member has one of the following:
    - A minimum body surface area (BSA) involvement of at least 10%
    - Eczema Area and Severity Index (EASI) score of at least 16
    - Physician Global Assessment (PGA) score of at least 3, \textit{AND}
  - The member has had a previous trial of at least two of the following preferred therapy categories without adequate response:
    - High-Potency Topical Corticosteroids
    - Topical Calcineurin Inhibitors (e.g., tacrolimus, pimecrolimus)
    - Phototherapy Ultraviolet Light A (PUVA)
    - Ultraviolet Light B (UVB)
    - Topical PDE-4 Inhibitors (e.g., crisaborole)
- Eosinophilic Asthma:
  - The member has a diagnosis of severe asthma, \textit{AND}
  - The member is currently utilizing a high dose inhaled corticosteroid (ICS) product plus either a long acting beta-2 agonist (LABA) or long acting muscarinic antagonist (LAMA), \textit{AND}
  - The member has documentation of blood eosinophils greater than or equal to 150 cells/mcl, measured within the preceding six months OR the member has been established on an alternative anti-IL-4/5 product (i.e., mepolizumab, reslizumab, or benralizumab).
- OCS Dependent Asthma:
  - The member has a diagnosis of severe asthma, \textit{AND}
  - The member is currently utilizing daily OCS and has been receiving OCS for at least 4 weeks, in addition to a high dose ICS product plus either a LABA or LAMA.
- CRSwNP:
For continuation: For atopic dermatitis, the member has experienced or maintained one of the following:
  - A reduction in BSA involvement of at least 20% from baseline
  - A decrease in EASI score of at least 50% from baseline
  - A PGA score of 0 or 1

For eosinophilic asthma:
  - The member has experienced a decrease in the frequency of exacerbations and improvement in symptoms, as attested to by the member’s specialist provider.

For OCS dependent Asthma:
  - The member has decreased their dose of OCS by at least 50%, OR
  - The member has decreased their dose of OCS by any amount and the member has experienced a decrease in the frequency of exacerbations and improvement in symptoms, as attested to by the member’s specialist provider.

For CRSwNP:
  - The member continues to have a beneficial response to therapy, as assessed by the member’s specialist provider.

Required Medical Information
  - For members treated for atopic dermatitis, current BSA coverage, EASI score, or PGA score
  - For members treated for eosinophilic asthma, an eosinophil count (cells/mcl) with date
  - For all indications, a treatment plan with all previous and concurrent therapies

Age Restrictions
  - Atopic Dermatitis and Asthma: 12 years of age and older
  - CRSwNP: 18 years of age and older

Prescriber Restrictions
  - Must be prescribed by a dermatologist, allergist, immunologist, or Ear, Nose and Throat (ENT) specialist

Reviewer Requirements
  - All coverage requests must be reviewed by a licensed pharmacist or physician

Coverage Duration
  - 6 months (initial); 12 months (continuation)

Quantity/Partial-Fill Restrictions
  - Atopic Dermatitis and Asthma:
    - For initial requests, enter two approvals by HICL as follows:
      - First approval: Approve one fill with a quantity limit of 4 mL (two 200 mg or 300 mg syringes)
      - Second approval: Approve for five months with a quantity limit of 4 mL (two syringes) per 28 days, with a start date two weeks after the start date of the first approval.
    - For continuation requests, approve for 12 months by HICL with a quantity of 4 mL (two syringes) per 28 days.
• CRSwNP:
  o Approve request with MDD of 0.15

Other Information

• Dupilumab is the fifth biologic approved for the treatment of severe asthma, but the first biologic approved for moderate-to-severe, and the first self-administered biologic in this space. Previously available biologic therapies include omalizumab (Xolair, anti-IgE dosed SQ once every two or four weeks), mepolizumab (Nucala, anti-IL-5 dosed SQ once every four weeks), reslizumab (Cinqair, anti-IL-5 dosed IV once every four weeks), and benralizumab (Fasenra, anti-IL-5R dosed SQ once every four weeks for three doses; then every eight weeks).

References