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)


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<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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H) **Failed/Contraindicated Therapies**

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.

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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: ____________

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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.

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*For Health Plan Use Only*

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<th>Request Date:</th>
<th>LOB:</th>
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<th>Denied:</th>
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<th>Approved By:</th>
<th>Denied By:</th>
<th>Effective Date:</th>
<th>Reason for Denial:</th>
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UNIVERSITY OF MICHIGAN – GRATEK (timothy grass pollen allergy extract)

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.

Note: Therapy for Grastek will not be approved less than 3 months prior to the typical grass pollen season. The grass pollen season generally runs from May through July. Therefore therapy will not be approved after February 1 of any given year.

1. Is the patient at least 5 years of age?  
   - Y  
   - N

2. Does the patient have allergic rhinitis?  
   - Y  
   - N

3. Has the patient had a positive skin test or positive IgE specific antibodies to timothy grass?  
   - Y  
   - N

4. Does the patient have additional allergies that require injectable allergen extract therapy?  
   - Y  
   - N

5. Will the first dose be administered in a healthcare facility and monitored for thirty minutes for signs and symptoms of a severe allergic reaction?  
   - Y  
   - N

6. Does the patient have any of the following conditions: compromised lung function, unstable angina, recent myocardial infarction, significant arrhythmia, or uncontrolled hypertension?  
   - Y  
   - N

7. Does the patient have severe, unstable or uncontrolled asthma?  
   - Y  
   - N

8. Does the patient have a history of eosinophilic esophagitis?  
   - Y  
   - N

9. Will the patient be provided auto-injectable epinephrine with instructions on when and how to use it?  
   - Y  
   - N

Effective June 1, 2016