

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 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

Fax: 858-790-7100

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

<input type="checkbox"/> Standard Review Request
<input type="checkbox"/> Expedited Review Request: <i>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.</i> 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 University of Michigan
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

Drug Name	Strength	Dosing Schedule	Duration	Adverse Event/Specific Failure
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

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: _____	



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 – Adalimumab (Humira, Amjevita, Cyltezo)

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: As of April 1, 2018, initial coverage of adalimumab is limited to the FDA-approved loading and maintenance dose (i.e., 40 mg every-other week). Coverage of requests exceeding this amount must be supported with documentation of remaining symptoms or lack of remission after three or more months of the initial maintenance regimen, unless the member has previously been established on 40 mg once weekly and decreasing the dose to 40 mg every-other week would put the member at severe risk for relapse or flare.

For All Conditions - Initial Requests		
1. Does your patient have a negative TB test prior to initiating therapy, or have received a complete treatment course for latent/underlying TB?	Y	N
For Moderate to Severe Rheumatoid Arthritis, Juvenile Idiopathic Arthritis, and Psoriatic Arthritis – Initial Requests		
1. Has your patient tried and failed, or is intolerant to, methotrexate monotherapy?	Y	N
2. Has your patient tried and failed, or is intolerant to, one or more alternative non-biologic DMARDs (i.e., hydroxychloroquine, sulfasalazine, leflunomide, or minocycline) for at least 12 weeks?	Y	N
For Ankylosing Spondylitis – Initial Requests		
1. Has your patient tried and failed two or more NSAIDs, steroid products, or methotrexate?	Y	N
For Plaque Psoriasis – Initial Requests		
1. Does your patient have \geq 10% BSA involvement of Plaque Psoriasis? BSA%: _____	Y	N
2. Does your patient have psoriatic plaques affecting palms, soles, head, neck, or genitalia?	Y	N
<i>Continued on next page</i>		

For Plaque Psoriasis – Initial Requests, Continued

3. Has your patient tried and failed, or is intolerant to, topical agents, topical immunomodulators, systemic therapy (i.e., methotrexate, cyclosporine, or acitretin), or phototherapy?	Y	N
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For Adult Crohn’s Disease, Ulcerative Colitis – Initial Requests

1. Does your patient have active, moderate-to-severe disease activity?	Y	N
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2. Is your patient considered “high-risk” (e.g., having perianal disease or fistula, history of bowel resections, facing imminent surgical intervention, having elevated C-reactive protein, or fecal calprotectin levels)?	Y	N
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3. Has your patient tried and failed two or more traditional therapies (i.e., mesalamine, sulfasalazine, methotrexate, azathioprine, sulfasalazine, or budesonide) within the previous 6 months?	Y	N
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4. Has your patient tried and failed one or more previous biologic therapies (i.e., infliximab, certolizumab, vedolizumab, golimumab, or natalizumab)?	Y	N
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For Pediatric Crohn’s Disease – Initial Requests

1. Does your patient have active, moderate-to-severe disease activity?	Y	N
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2. Has your patient tried and failed one or more traditional therapies (i.e., mesalamine, sulfasalazine, methotrexate, azathioprine, sulfasalazine, or budesonide) within the previous 6 months?	Y	N
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3. Has your patient tried and failed one or more previous biologic therapies (i.e., infliximab, certolizumab, vedolizumab, golimumab, or natalizumab)?	Y	N
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4. Patient weight (kg): _____ Date: _____

For Hidradenitis Suppurativa – Initial Requests

1. Does your patient have a diagnosis of hidradenitis suppurativa with severity of Hurley Stage II-III? Hurley Stage: _____	Y	N
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Continued on next page

For Hidradenitis Suppurativa – Initial Requests, Continued.

2. Has your patient failed to show significant improvement with systemic antibiotic therapy of at least 4 months in duration.?	Y	N
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For Uveitis – Initial Requests

1. Does your patient have a diagnosis of uveitis?	Y	N
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2. Does your patient have a diagnosis of isolated anterior uveitis?	Y	N
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For Continuation or Increased Dose Requests

1. Does your patient continue to have a beneficial response to therapy? <i>If not, please include rationale for continuation of therapy.</i>	Y	N
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2. For requests to increase dose to 40 mg every-week, does your patient have continued symptoms after three months of maintenance therapy at the current dose?	Y	N
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3. For requests to increase dose to 40 mg every-week, does your patient have inflammatory markers (e.g., elevated C-reactive protein) suggesting continued inflammation after three months of maintenance therapy at the current dose?	Y	N
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4. For <u>Ulcerative Colitis</u> : Does your patient have evidence of remission at week 8 of therapy?	Y	N
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Effective April 1, 2018