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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<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>
<th>Approved:</th>
<th>Denied:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approved By:</td>
<td></td>
<td></td>
<td>Denied By:</td>
</tr>
</tbody>
</table>

Effective Date: ____________________________

Reason for Denial: ____________________________

Additional Comments:__________________________________________
UNIVERSITY OF MICHIGAN – – INFERTILITY - Menotropins

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.

<table>
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<th>Brand name (generic):</th>
<th>Menopur (menotropins)</th>
<th>Reprofax (menotropins)</th>
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</thead>
</table>

You must answer ALL questions related to your patient's condition

INFERTILITY: MALES & FEMALES – answer questions 1 & 2, and the gender specific questions

1. Does the patient have a diagnosis of infertility?  
   Y  N

2. Has the patient's partner been evaluated for fertility potential AND been found to be fertile?  
   N/A  Y  N

INFERTILITY: FEMALES

3. Is the patient pregnant?  
   Y  N

4. Does the patient have a diagnosis of primary ovarian failure?  
   Y  N

5. Is the patient undergoing development of multiple follicles/ovulation induction and pregnancy and participating in an Assisted Reproductive Technology (ART) program?  
   Y  N

6. (Repronex only): Will this medication be used in conjunction with human chorionic gonadotropin (hCG) and has the patient previously received pituitary suppression?  
   N/A  Y  N

INFERTILITY: MALES

7. Does the patient have a diagnosis of hypogonadotropic hypogonadism?  
   Y  N

8. Will the medication be given in conjunction with human chorionic gonadotropin (hCG)?  
   Y  N

N/A = not applicable

U-M Prescription Drug Plan benefit for infertility medications is limited to a LIFETIME family maximum of 5 total prescription fills of follitropins and menotropins. Maximum quantities per prescription apply. Prior authorization will not increase this benefit level.

Effective June 1, 2016