# 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**

| 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: _____ | |

**UNIVERSITY OF MICHIGAN – Kineret (Anakinra)**

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.

| **Answer questions 1-3 for all patients AND the questions related to your patient's diagnosis.** | | |
|---|---|---|
| 1. Has the patient been evaluated for active infection before treatment and will the patient be monitored for signs and symptoms of infection during and after treatment with Kineret? | Y | N |
| 2. Will the patient be monitored for potential complications of Kineret therapy (e.g., serious infections, lymphoma and other malignancies, hypersensitivity reactions)? | Y | N |
| 3. Will the patient receive concurrent live vaccines, Enbrel (etanercept) or other biologic treatment options during treatment with Kineret? | Y | N |
| **RHEUMATOID ARTHRITIS (also answer questions 4 - 7)** | | |
| 4. Is the patient age 18 years or older? | Y | N |
| 5. Does the patient have the diagnosis of moderately to severely active rheumatoid arthritis? | Y | N |
| 6. Has the patient tried and failed one or more disease modifying antirheumatic drugs (DMARDs) (e.g. methotrexate)? | Y | N |
| 7. Has the Kineret therapy been prescribed or recommended by a Rheumatologist? | Y | N |
| **CRYOPYRIN-ASSOCIATED PERIODIC SYNDROME (CAPS) (also answer question #8)** | | |
| 8. Does the patient have a diagnosis of Cryopyrin-Associated Periodic Syndromes (CAPS): Neonatal-Onset Multisystem Inflammatory Disease (NOMID)? | Y | N |
| **FAMILIAL MEDITERRANEAN FEVER (FMF) (also answer questions 9-12)** | | |
| 9. Is the patient resistant to colchicine or intolerant to colchicine therapy? | Y | N |
| 10. Is the patient age 2 or older? | Y | N |
| 11. Does the patient have a diagnosis of Familial Mediterranean Fever (FMF) confirmed by a genetic test? | Y | N |
| 12. Has the patient tried and failed Ilaris (Cankinumab) ? | Y | N |

Effective June 28, 2017