

# 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: _____	



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**UNIVERSITY OF MICHIGAN – NUCYNTA, NUCYNTA ER (tapentadol)**

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.

<b>All Nucynta Requests – Please answer questions 1 &amp; 2</b>		
1. Is the patient 18 years of age or older?	Y	N
2. Does the patient have any of the following contraindications: (circle any that apply) -Have impaired pulmonary function? -Have or is suspected of having paralytic ileus? -Is using or has used a monoamine oxidase inhibitor within the last 14 days? -Have severe renal or hepatic impairment?	Y	N
<b>Nucynta (immediate release) Requests – Please answer questions 3 - 7</b>		
3. Is the requested drug Nucynta (immediate release)	Y	N
4. Is the patient experiencing moderate to severe acute pain?	Y	N
5. Does the patient have a documented trial and failure or intolerance to at least three formulary immediate release narcotic medications? (i.e., morphine sulfate, oxycodone, hydromorphone, hydrocodone/APAP, etc.)	Y	N
6. Is the intended duration of therapy 30 days or less?	Y	N
7. Will immediate release Nucynta be used to address breakthrough pain for a patient who has already been approved and is using Nucynta ER for chronic pain?	Y	N
<b>Nucynta ER Requests – Please answer questions 8 - 12</b>		
8. Is the requested medication Nucynta ER?	Y	N
9. Is the patient being treated for neuropathic pain associated with diabetic peripheral neuropathy?	Y	N
10. Has the patient tried at least two of the following agents for at least 14 days each or are these agents contraindicated? pregabalin, gabapentin, sodium valproate, amitriptyline, venlafaxine, or duloxetine.	Y	N
11. Does the patient require around-the-clock, chronic pain management with an opioid?	Y	N
12. Has the patient tried at least two long-acting preferred opioids (such as morphine sulfate, oxycodone, hydromorphone, etc.) without adequate pain control?	Y	