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)

☐ **Standard Review Request**

☐ **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 ☒ 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: _____

HUMAN RESOURCES
BENEFITS OFFICE
UNIVERSITY OF MICHIGAN

UNIVERSITY OF MICHIGAN – PCSK-9 Inhibitors: Evolocumab (Repatha), Alirocumab (Praluent)

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.

For Initial Requests; Please answer the following questions for your patient: Note: Coverage requests must include clinical documentation supporting all of the following questions, as applicable		
1. Does your patient have established atherosclerotic cardiovascular disease? *If yes, please attach supporting documentation (e.g. history of hospital admission, imaging study, or surgical procedure).*	Y	N
2. Does your patient have Heterozygous Familial Hypercholesterolemia (HeFH) as established by one of the following: a. Confirmed genetic testing b. Dutch Lipid Network clinical criteria c. Simon-Broome criteria *If yes, please attach supporting documentation for the diagnostic criteria met.*	Y	N
3. Does your patient have Homozygous Familial Hypercholesterolemia (HoFH) as evidenced by one of the following: a. Confirmed genetic testing b. An untreated LDL-C ≥ 500 mg/dL c. A treated LDL-C ≥ 300 mg/dL *AND* one of the following: i. Cutaneous or tendinous xanthoma before the age of 10 years ii. Untreated LDL-C levels consistent with heterozygous familial hypercholesterolemia in both parents (greater than 190 mg/dL)	Y	N
4. Has your patient had an inadequate response (i.e., LDL-C greater than 70 mg/dL while on therapy) to maximally tolerated atorvastatin or rosuvastatin therapy in combination with ezetimibe, unless otherwise contraindicated or intolerant to statin therapy? NOTE: Statin intolerance requires the following: • Documentation of severe and intolerable adverse effects that have occurred with every trial of statin, and other potential causes were ruled out (low vitamin D levels, sudden increase in intense or prolonged physical activity, drug interactions with statins, or other metabolic or inflammatory causes), AND • Patient tried alternate dosing strategies such as every-other-day statin dosing or twice weekly dosing, AND • Documentation of at least ONE of the following lab values or incidents: ○ CK increase to 10 times upper limit of normal during statin therapy ○ LFTs increase to 3 times upper limit of normal during statin therapy ○ Hospitalization due to severe adverse event such as rhabdomyolysis during statin therapy ○ Severe muscle weakness leading to temporary disability, fall, or inability to use a major muscle group during statin therapy (e.g., unable to stand from a seated position or inability to exit a motor vehicle without assistance.)	Y	N
For Continuation Requests; Please answer the following questions for your patient:		
1. Has your patient continued to experience clinical benefit while on therapy with the requested medication?	Y	N

Revised November 20, 2019