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

(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 [x] 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**

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Strength</th>
<th>Dosing Schedule</th>
<th>Duration</th>
<th>Adverse Event/Specific Failure</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

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.

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

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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: ____________

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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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DIFS is an equal opportunity employer/program. Auxiliary aids, services and other reasonable accommodations are available upon request to individuals with disabilities. Visit DIFS online at: www.michigan.gov/difs  Phone DIFS toll-free at: 877-999-6442
UNIVERSITY OF MICHIGAN – 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.

Please answer the following questions for your patient:

<table>
<thead>
<tr>
<th>Question</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Does your patient have a diagnosis of atherosclerotic cardiovascular disease (ASCVD)?</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>2. Does your patient have a diagnosis of Familial Hypercholesterolemia (FH)?</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>3. Has your patient tried and failed six-month therapies of both high-intensity atorvastatin (80 mg) and rosuvastatin (40 mg) therapies, unless otherwise contraindicated or intolerant*?</td>
<td></td>
<td></td>
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<tr>
<td>*Please note that statin intolerance requires the following:</td>
<td></td>
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<tr>
<td>• 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</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>• Documentation that the patient has tried alternate dosing strategies such as every-other-day statin dosing or twice weekly dosing, AND</td>
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<td>• Documentation of at least one of the following lab values or incidents:</td>
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<td>o CK increase to 10 times upper limit of normal during statin therapy</td>
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<tr>
<td>o LFTs increase to 3 times upper limit of normal during statin therapy</td>
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<tr>
<td>o Hospitalization due to severe adverse event such as rhabdomyolysis during statin therapy</td>
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<tr>
<td>o 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.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Does your patient have documentation of baseline fasting LDL levels of greater than 100 mg/dL if currently on high-intensity statin therapy?</td>
<td>Y</td>
<td>N</td>
</tr>
</tbody>
</table>
5. Does your patient have documentation of baseline fasting LDL levels greater than 160 mg/dL if intolerant to high-intensity statin therapy plus non-statin therapy?  

| Y | N |

6. *For patients with ASCVD*: does your patient have supporting documentation of atherosclerotic cardiovascular disease, such as history of hospital admission, imaging study, or surgical procedure?  

| Y | N |

7. *For patients with FH*: does your patient have a diagnosis of heterozygous or homozygous familial hypercholesterolemia (HeFH, HoFH), supported by either a Simon Broome diagnostic criteria for HeFH or Dutch Lipid Network criteria of at least 6?  

| Y | N |

8. *For patients with FH*: Does your patient have a clinical diagnosis of FH with LDL-C >500 mg/dL with either,  
   a. Xanthoma before 10 years of age  
   b. Evidence of HeFH in both parents  

| Y | N |

9. *For continuation requests*, has your patient been adherent to therapy and, as attested to by the treating provider?  

| Y | N |