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**

<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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</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.

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

Effective Date: ____________________________________________

Reason for Denial: ________________________________________

Additional Comments: ____________________________________

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**Michigan Department of Insurance and Financial Services**

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UNIVERSITY OF MICHIGAN – SOMAVER (pegvisomant)

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 ALL QUESTIONS

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<tbody>
<tr>
<td>1.</td>
<td>Is the patient age 18 or older?</td>
<td>Y N</td>
</tr>
<tr>
<td>2.</td>
<td>Does the patient have a diagnosis of acromegaly?</td>
<td>Y N</td>
</tr>
<tr>
<td>3.</td>
<td>Do any of the following situations apply? (circle all those that apply)</td>
<td>Y N</td>
</tr>
<tr>
<td></td>
<td>• Tried surgery, radiation therapy, or medical treatment</td>
<td></td>
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<td></td>
<td>• Inadequate response to surgery, radiation therapy, or medical treatment</td>
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<td>• Other treatment have been considered and deemed inappropriate or contraindicated</td>
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<td>4.</td>
<td>Is the patient’s serum insulin-like growth factor 1 (IGF-1) levels above the age and gender adjusted normal range?</td>
<td>Y N</td>
</tr>
<tr>
<td>5.</td>
<td>Will monitoring include BOTH:</td>
<td>Y N</td>
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<td></td>
<td>• patient’s serum insulin-like growth factor 1 (IGF-1) levels at 6 month intervals after normalized</td>
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<td>• liver function testing as recommended by manufacturer?</td>
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Effective July 5, 2016