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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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*

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<thead>
<tr>
<th>Request Date:</th>
<th>LOB:</th>
<th>Approved:</th>
<th>Denied:</th>
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<tr>
<td></td>
<td></td>
<td>Approved By:</td>
<td>Denied By:</td>
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Effective Date: ______________________  Reason for Denial: ______________________

Additional Comments: ______________________
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 QUESTIONS 1 THROUGH 10 BELOW**

<table>
<thead>
<tr>
<th>Question</th>
<th>Y</th>
<th>N</th>
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<tbody>
<tr>
<td>1. Is treatment with Sovaldi being prescribed and monitored by a hepatologist?</td>
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<td>2. Is the patient ≥ 18 years of age</td>
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<td>3. Has pregnancy been ruled out for the patient if female or for the patient’s female partner if male AND will the patient or the male patient’s female partner be advised to use 2 methods of contraception AND will pregnancy be ruled out monthly during treatment and for 6 months following treatment?</td>
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<td>4. Is the patient currently receiving another protease inhibitor for hepatitis C (e.g. Incivek, Victrelis, or Olysio)?</td>
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<td>5. Will Sovaldi be used uninterrupted in combination with ribavirin for the specific FDA-approved dosing regimen?</td>
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<td>6. If ribavirin is discontinued for any reason, will the patient’s Sovaldi treatment also be discontinued?</td>
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<td>7. Which genotype of chronic hepatitis C is the patient diagnosed with?</td>
<td>1</td>
<td>2</td>
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<td>8. Does the patient have hepatocellular carcinoma meeting Milan criteria (awaiting liver transplant)?</td>
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<td>9. Does the patient have autoimmune hepatitis with hypersensitivity to interferons</td>
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<td>10. Will Sovaldi be used with interferon?</td>
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