

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: _____	



Michigan Department of Insurance and Financial Services

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UNIVERSITY OF MICHIGAN – STADOL NS (butorphanol)

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.

Use this form ONLY for request for quantities in excess of 1 bottle/month

One (1) bottle per month is payable without a prior authorization		
You must also answer ALL questions related to you patient’s condition or Dx		
For ALL patients, answer question 1		
1. Is the patient over age 65? (if no, move to Dx specific sections, if yes answer question 2)	Y	N
2. Is the physician aware of the dosage adjustments recommended for the geriatric patient with butorphanol NS?	Y	N
PAIN MANAGEMENT – also answer questions 3 through 6		
3. Does the patient have pain (including postoperative) AND is unable to take oral medications (including liquids)?	Y	N
4. Has the patient failed other opioid pain management regimens?	Y	N
5. Does the patient require more than 1 bottle per month? (Each bottle delivers 14-15 doses)	Y	N
6. How many bottles are needed per month for treatment?		
MIGRAINE PAIN MANAGEMENT – also answer questions 7 through 11		
7. Does the patient have the diagnosis of moderate to severe migraine headache?	Y	N
8. Has the patient tried and failed at least 2 other abortive migraine therapy agents (e.g., acetaminophen, NSAIDs, Fioricet or Midrin, Imitrex, or Migranal or Cafergot)? Please list 2 agents tried:	Y	N
9. Does the patient experience more than 3 - 4 migraine headaches per month?	Y	N
10. Has prophylactic therapy been considered?	Y	N
11. Has the possibility of medication-induced, rebound, or chronic daily headache been considered?	Y	N