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: _____	

UNIVERSITY OF MICHIGAN – STIMULANTS

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.

Adderall (amphetamine mixture) **Dextroamphetamine** (includes Dexedrine, Procentra, Zenzedi)	**Desoxyn** (methamphetamine) **Methylphenidate** (includes Concerta, Metadate, Ritalin products, Methylin)	**Focalin & Focalin XR** (dexmethylphenidate) **Vyvanse** (lisdexamfetamine)		
You must also answer ALL questions related to your patient's condition				
For all patients, answer question 1, PLUS the Diagnosis specific questions				
1. Will the patient be regularly monitored for adverse events, including weight loss and decreased growth velocity for children, and long-term usefulness?			Y	N
ADD/ADHD: (also answer questions 2 & 3)				
2. Does the patient have a diagnosis of ADD/ADHD?			Y	N
3. Are the ADHD symptoms causing clinically significant impairment in social, academic, or occupational functioning?			Y	N
NARCOLEPSY: (also answer questions 4 and 5)				
4. Does the patient have a diagnosis of narcolepsy or idiopathic hypersomnia, which is confirmed by polysomnography and an average sleep latency for 5 naps during multiple sleep latency test of ≤ 8 minutes?			Y	N
5. Has the patient been evaluated for other causes of excessive daytime sleepiness (e.g., insufficient sleep syndrome, upper airway resistance syndrome, depression)?			Y	N
FATIGUE ASSOCIATED w/ MULTIPLE SCLEROSIS: (also answer questions 6 & 7)				
6. Does the patient have a diagnosis of multiple sclerosis?			Y	N
7. Does the patient experience secondary fatigue?			Y	N
CANCER-RELATED FATIGUE: (also answer questions 8, 9 & 10)				
8. Is the patient experiencing fatigue associated with cancer therapy (active treatment, post treatment, or end of life)?			Y	N
9. Have other potential causes of fatigue been ruled out or addressed?			Y	N
10. Is the prescribed medication methylphenidate?			Y	N
BINGE EATING DISORDER (Vyvanse only; please also answer questions 11-16)				
11. Does the patient have a diagnosis of binge eating disorder based on DSM 5 criteria?			Y	N
12. Has the patient had at least one trial (4-6 weeks) of antidepressants including sertraline, fluoxetine and bupropion without adequate results or are these medications contraindicated or not tolerated?			Y	N
13. Will Vyvanse be used in conjunction with behavioral therapy such as cognitive behavioral therapy or interpersonal psychotherapy?			Y	N
14. Is the patient aware that Vyvanse is unlikely to cause weight loss?			Y	N
15. Does the patient have secondary medical conditions or dysfunction associated with binge eating disorder?			Y	N
16. Will the patient be monitored by an internist to address secondary medical conditions during treatment or complications related to Vyvanse?			Y	N

Effective August 15, 2017