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 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.

Print Reset

Michigan Prior Authorization
Request Form for Prescription Drugs

Fax: 800-424-7648

(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 ☒ University of Michigan 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

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: _____

Member's Last Name:

Member's First Name:

University of Michigan – Stelara® (ustekinumab)

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.

Initial Request – Psoriatic Arthritis		
Does the member have a diagnosis of active psoriatic arthritis (PsA)?	**Y**	**N**
For a diagnosis of PsA with concurrent psoriasis (PsO), what is the member's current weight?		
Does the member have a previous trial of at least **ONE** or more of the following or a contraindication to at least **ONE** or more of the following? • Methotrexate • Cyclosporine • Leflunomide • Sulfasalazine ***Please supply supporting documentation (claims/medical records) demonstrating use of previous therapies.***	**Y**	**N**
The member will **NOT** be receiving concurrent treatment with another monoclonal antibody biologic, tumor necrosis factor (TNF) inhibitor, biologic response modifier, or potent non-biologic agent (e.g., abrocitinib, apremilast, tofacitinib, baricitinib, upadacitinib). Is this statement **TRUE**?	**Y**	**N**
Is the member 6 years of age or older?	**Y**	**N**
Is the medication being prescribed by or in consultation with a rheumatologist or a dermatologist?	**Y**	**N**

Continued on next page.

HUMAN RESOURCES BENEFITS OFFICE UNIVERSITY OF MICHIGAN | MagellanRx MANAGEMENT

Member's Last Name:

Member's First Name:

Initial Request – Psoriasis		
Does the member have psoriatic lesions that involve ≥ 10% of body surface area (BSA) or that affect the palms, soles, head, neck, or genital area leading to disability/impact on quality of life?	**Y**	**N**
Please submit documentation of member's current BSA coverage of lesions.		
Has the member had a previous trial of **ONE** or more of the following or a contraindication to **ONE** or more of the following? • Acitretin • Calcipotriene • Cyclosporine • Methotrexate • Phototherapy ultraviolet light A (PUVA)/Ultraviolet light B (UVB) • Topical corticosteroids ***Please supply supporting documentation (claims/medical records) demonstrating use of previous therapies.***	**Y**	**N**
The member will **NOT** be receiving concurrent treatment with another monoclonal antibody biologic, tumor necrosis factor (TNF) inhibitor, biologic response modifier, or potent non-biologic agent (e.g., abrocitinib, apremilast, tofacitinib, baricitinib, upadacitinib). Is this statement **TRUE**?	**Y**	**N**
Is the member 6 years of age or older?	**Y**	**N**
What is the member's current weight?		
Is the medication being prescribed by or in consultation with a rheumatologist or a dermatologist?	**Y**	**N**
Initial Request – Crohn's Disease		
Does the member have a diagnosis of moderately to severely active Crohn's disease (CD)?	**Y**	**N**
Has the member had a previous trial of at least **ONE** of the following therapy options or categories without adequate response or a contraindication to at least **ONE** of the following therapy options or categories? • Thiopurines (e.g., 6-mercaptopurine or azathioprine) • Corticosteroids • Methotrexate ***Please supply supporting documentation (claims/medical records) demonstrating use of previous therapies.***	**Y**	**N**

Continued on next page.

Member's Last Name: | | | | | | | | | | | | |

Member's First Name: | | | | | | | | | | | | |

Has the member tried and failed **ONE** or more previous biologic therapies (e.g., adalimumab, risankizumab, infliximab, certolizumab, vedolizumab, golimumab, or natalizumab)? ***Please supply supporting documentation (claims/medical records) demonstrating use of previous therapies.***	**Y**	**N**
The member will **NOT** be receiving concurrent treatment with another monoclonal antibody biologic, tumor necrosis factor (TNF) inhibitor, or biologic response modifier, potent non-biologic agent (e.g., abrocitinib, apremilast, tofacitinib, baricitinib, upadacitinib). Is this statement **TRUE**?	**Y**	**N**
Is the member 18 years of age or older?	**Y**	**N**
Is the medication being prescribed by or in consultation with a gastroenterologist?	**Y**	**N**
Initial Request – Ulcerative Colitis		
Does the member have a diagnosis of moderately to severely active ulcerative colitis (UC)?	**Y**	**N**
Has the member had a previous trial of at least **ONE** of the following or contraindication to at least **ONE** of the following? • Thiopurines (e.g., 6-mercaptopurine or azathioprine) • Corticosteroids ***Please supply supporting documentation (claims/medical records) demonstrating use of previous therapies.***	**Y**	**N**
Has the member tried and failed **ONE** or more previous biologic therapies (e.g., infliximab, certolizumab, vedolizumab, golimumab, ustekinumab, or natalizumab)? ***Please supply supporting documentation (claims/medical records) demonstrating use of previous therapies.***	**Y**	**N**
The member will **NOT** be receiving concurrent treatment with another monoclonal antibody biologic, tumor necrosis factor (TNF) inhibitor, biologic response modifier, or potent non-biologic agent (e.g., abrocitinib, apremilast, tofacitinib, baricitinib, upadacitinib). Is this statement **TRUE**?	**Y**	**N**
Is the member 18 years of age or older?	**Y**	**N**
Is the medication being prescribed by or in consultation with a gastroenterologist?	**Y**	**N**

Continued on next page.

HUMAN RESOURCES BENEFITS OFFICE UNIVERSITY OF MICHIGAN | MagellanRx MANAGEMENT

Member's Last Name:

Member's First Name:

Renewal Request		
Has the member had a positive clinical response to therapy, as documented by the member's specialist provider?	**Y**	**N**
The member is **NOT** receiving concurrent treatment with another monoclonal antibody biologic, tumor necrosis factor (TNF) inhibitor, biologic response modifier, or potent non-biologic agent (e.g., abrocitinib, apremilast, tofacitinib, baricitinib, upadacitinib). Is this statement **TRUE**?	**Y**	**N**
Dose Escalation Request		
Has the member had six months of continuous, on-label dosing and documentation of therapeutic failure to the FDA-approved regimens? ***Please supply supporting documentation (claims/medical records) demonstrating use of previous therapies.***	**Y**	**N**
Does the provider attest that alternative therapies, including the concurrent use of non-biologic therapies, have been considered prior to dose escalation?	**Y**	**N**
The member is **NOT** receiving concurrent treatment with another monoclonal antibody biologic, tumor necrosis factor (TNF) inhibitor, biologic response modifier, or potent non-biologic agent (e.g., abrocitinib, apremilast, tofacitinib, baricitinib, upadacitinib). Is this statement **TRUE**?	**Y**	**N**