

## 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.**

**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     Prime Therapeutics     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\***

<b>Request Date:</b> _____	<b>LOB:</b> _____
<b>Approved:</b> _____	<b>Denied:</b> _____
<b>Approved By:</b> _____	<b>Denied By:</b> _____
<b>Effective Date:</b> _____	<b>Reason for Denial:</b> _____
<b>Additional Comments:</b> _____	



**Michigan Department of Insurance and Financial Services**

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Phone DIFS toll-free at: 877-999-6442



Member's Last Name:

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Member's First Name:

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### University of Michigan – Ingrezza® (valbenazine)

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 – Tardive Dyskinesia		
Does the member have a diagnosis of tardive dyskinesia?	Y	N
Has the member experienced the tardive dyskinesia for longer than 3 months (chronic)?	Y	N
Has the member either failed or cannot tolerate withdrawal of dopamine antagonists?	Y	N
Has the member been using antipsychotic medications or dopamine D2 antagonists for at least 3 months (or at least 1 month if member is 60 years of age or older) as documented in the prescription claims history or chart notes?  <i>Please supply supporting documentation (claims or medical records) demonstrating use of previous therapies.</i>	Y	N
The member will <b>NOT</b> be taking a concurrent vesicular monoamine transporter 2 (VMAT2) inhibitor. Is this statement <b>TRUE</b> ?	Y	N
Is the member 18 years of age or older?	Y	N
Is the medication being prescribed by or in consultation with a neurologist, movement disorder specialist, or psychiatrist?	Y	N

*Continued on next page.*

**Member's Last Name:**

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**Member's First Name:**

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Initial Request – Chorea Associated with Huntington's Disease		
Does the member have a diagnosis of chorea associated with Huntington's disease?	<b>Y</b>	<b>N</b>
The member will <b>NOT</b> be taking a concurrent VMAT2 inhibitor. Is this statement <b>TRUE</b> ?	<b>Y</b>	<b>N</b>
The member has tried and failed, or is contraindicated to, tetrabenazine. Is this statement <b>TRUE</b> ?	<b>Y</b>	<b>N</b>
<i>Please supply supporting documentation (claims or medical records) demonstrating use of previous therapies.</i>		
Is the member 18 years of age or older?	<b>Y</b>	<b>N</b>
Is the medication being prescribed by or in consultation with a neurologist, movement disorder specialist, or psychiatrist?	<b>Y</b>	<b>N</b>