# 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 |
|---|---|---|---|---|
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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***

**Request Date:** _____ **LOB:** _____

**Approved:** _____ **Denied:** _____

**Approved By:** _____ **Denied By:** _____

**Effective Date:** _____ **Reason for Denial:** _____

**Additional Comments:** _____

**Member's Last Name:**

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**Member's First Name:**

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## University of Michigan – Camzyos® (mavacamten)

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 Requests | | |
|---|---|---|
| Does the member have unexplained left ventricular hypertrophy with maximal left ventricular wall thickness of >15 mm (or >13 mm if familial hypertrophic cardiomyopathy)? | **Y** | **N** |
| Does the member have a peak left ventricular outflow tract (LVOT) gradient > 50 mmHg? | **Y** | **N** |
| Does the member have New York Heart Association (NYHA) class II–III symptoms? | **Y** | **N** |
| Does the member have a left ventricular ejection fraction (LVEF) >55%? | **Y** | **N** |
| Will the member be monitored with regular echocardiograms? | **Y** | **N** |
| The member will not be taking a moderate to strong CYP2C19 inhibitor or inducer, strong CYP3A4 inhibitor, or moderate to strong CYP3A4 inducer with the requested medication. Is this statement **true**? | **Y** | **N** |
| Has the member tried and failed, or had a contraindication to, **all** of the following: a beta-blocker, a calcium-channel blocker, and disopyramide?<br>*If **yes** to the previous question, document the specific medication(s), date of trial(s), and clinical outcomes*. | **Y** | **N** |
| Has the member been evaluated for eligibility for septal ablation or septal myectomy? | **Y** | **N** |
| Is the requested medication being prescribed by, or in consultation with, a cardiologist? | **Y** | **N** |
| Has documentation been provided of the maximal left ventricular wall thickness, LVOT, NYHA class, and LVEF? | **Y** | **N** |

***Continued on next page.***



 Revised: 10/22/2022| Effective: 06/02/2022

**Member's Last Name:**

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**Member's First Name:**

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| **Renewal Requests** | | |
|---|---|---|
| Has the member experienced an improvement in symptoms, peak oxygen consumption (pVO2), or peak left ventricular outflow tract (LVOT) gradient? | **Y** | **N** |
| Does the member have a left ventricular ejection fraction (LVEF) >55%? | **Y** | **N** |
| The member has been and will continue to be monitored with regular echocardiograms. Is this statement **true**? | **Y** | **N** |
| The member will not be taking a moderate to strong CYP2C19 inhibitor or inducer, strong CYP3A4 inhibitor, or moderate to strong CYP3A4 inducer with the requested medication. Is this statement **true**? | **Y** | **N** |
| What is the member's LVEF? | | |
| Is the requested medication being prescribed by, or in consultation with, a cardiologist? | **Y** | **N** |



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