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 ☐ 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

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 – Growth Hormone (somatropin, somapacitan, somatrogon, and lonapegsomatropin)

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 – Pediatric Member (less than 18 years of age)		
Omnitrope®, Genotropin®, and Genotropin Miniquick® are the sole preferred growth hormone products. All requests for other non-preferred products must try and fail Omnitrope® OR Genotropin®/Genotropin Miniquick®.		
Please supply documentation of the member's current height, weight, and lab results confirming diagnosis (as applicable).		
Does the member have epiphyses open, as confirmed by wrist film or other evaluation and one of the following diagnoses? ▪ Chronic renal failure and growth retardation, **OR** ▪ Short stature homeobox gene (SHOX) deficiency, **OR** ▪ Turner syndrome, Noonan syndrome, or Prader-Willi syndrome, **OR** ▪ Idiopathic short stature, **OR** ▪ Small for gestational age (SGA) ***If the member has a diagnosis of idiopathic short stature or SGA, see the following questions.***	**Y**	**N**

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Revised: 08/09/2024 | Effective: 04/01/2024

Member's Last Name:

Member's First Name:

If the member has a diagnosis other than idiopathic short stature, this question can be skipped. Does the member meet the following criteria? ▪ The member has a height less than or equal to -2.25 standard deviations (SD) below the corresponding mean height for age and sex, **AND** ▪ The member has been evaluated for and does not have a diagnosis of constitutional delay of growth ad puberty (CDGP), **AND** ▪ **ONE** of the following: o The member has a predicted adult height that is below the normal range, **AND** ▪ **ONE** of the following: o The member's sex is male and predicted adult height is less than 63 inches, **OR** o The member's sex is female and predicted adult height is less than 59 inches, **OR** o The member is more than 2 SD below their mid-parental target height.	**Y**	**N**
If the member has a diagnosis other than SGA, this question can be skipped. Does the member meet the following criteria? ▪ The member is 2 years of age or older, **AND** ▪ The member has a documented birth weight and/or birth length that is 2 or SD below the mean for gestational age, **AND** ▪ At 24 months of age, the member failed to manifest catch-up growth evidenced by a height that remains 2 or more SD below the mean for age and sex	**Y**	**N**
Does the member have a diagnosis of growth hormone (GH) deficiency and meet the following criteria? ▪ Documented failure of at least one GH stimulation test (defined as a peak growth hormone level of less than 10 mcg/L after GH stimulation by insulin, arginine, clonidine, glucagon, or levodopa), **AND** ▪ One of the following: o Growth velocity is subnormal, **OR** o Bone age is delayed	**Y**	**N**

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Revised: 08/09/2024 | Effective: 04/01/2024

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

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

Does the member meet the age requirement for the product being requested? ▪ Somatropin or somapacitan: 2 years of age and older ▪ Somatrogon: 3–17 years of age ▪ Lonapegsomatropin: 1–17 years of age	**Y**	**N**
Is the medication being prescribed by or in consultation with an endocrinologist or pediatric nephrologist?	**Y**	**N**

Initial Request – Adult Member (18 years of age and older)

Omnitrope®, Genotropin®, and Genotropin Miniquick® are the sole preferred growth hormone products. All requests for other non-preferred products must try and fail Omnitrope® OR Genotropin®/Genotropin Miniquick®.

Please supply documentation of the member's current height, weight, and lab results confirming diagnosis, as applicable.

Does the member have a diagnosis of human immunodeficiency virus (HIV) and an unintentional weight loss of 10% over the past 12 months or a BMI less than 18.5?	**Y**	**N**
Does the member have a diagnosis of documented GH deficiency and has the member failed two growth hormone stimulation tests?	**Y**	**N**
Does the member have a diagnosis of short bowel syndrome?	**Y**	**N**
If YES to the previous question: Is the member currently receiving specialized nutrition support directed by a healthcare professional (total parenteral nutrition [TPN], peripheral parenteral nutrition [PPN], or high-complex carbohydrate, low-fat diet) and maintaining appropriate daily caloric intake requirements?	**Y**	**N**
Does the member meet the age requirement for the product being requested? ▪ Somatropin or somapacitan: 2 years of age and older ▪ Somatrogon: 3–17 years of age ▪ Lonapegsomatropin: 1–17 years of age	**Y**	**N**
Is the medication being prescribed by or in consultation with an endocrinologist or pediatric nephrologist?	**Y**	**N**

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Revised: 08/09/2024 | Effective: 04/01/2024

HUMAN RESOURCES BENEFITS OFFICE UNIVERSITY OF MICHIGAN | Prime THERAPEUTICS™

Member's Last Name:

Member's First Name:

Renewal Request – Pediatric Member (less than 18 years of age)		
Does the the member's specialist provider attest that the member continues to have a beneficial response to therapy, as assessed and documented?	**Y**	**N**
Is the member's growth velocity is 2 cm/year or more?	**Y**	**N**
Please supply documentation of the member's current height and weight.		
Renewal Request – Adult Member (18 years and older)		
Does the the member's specialist provider attest that the member continues to have a beneficial response to therapy, as assessed and documented?	**Y**	**N**
Please supply documentation of the member's current height and weight.		

Revised: 08/09/2024 | Effective: 04/01/2024