RE: Prescription Drug Prior Authorization Request

Pursuant to Michigan Compiled Laws (MCL) Section 500.2212e, beginning June 1, 2023, prescription benefit coverage requests **must be submitted utilizing electronic prior authorization (ePA). Information on how to submit an ePA can be found at Caremark.com/epa. If you are unable to use e-PA** due to a temporary technological or electrical failure**, please fill out the certification below. PRIOR AUTHORIZATIONS SUBMITTED VIA FAX WITHOUT A CERTIFICATION WILL NOT BE PROCESSED.**

Note: The attached criteria is provided for informational purposes only and can be used to assist in filling out the online ePA request.

Please indicate below if you are experiencing a temporary technological or electrical failure and are unable to pursue the ePA process. Requests will not be processed without this certification.

You must submit this faxed document to 1-888-836-0730 for non-specialty medications and 1-866-249-6155 for specialty medications and check the appropriate box signifying temporary technological or electrical failure to start the PA request. You must resubmit the prior authorization including all clinically relevant information, along with this completed form, to initiate processing. Failure to submit this form with the prior authorization documentation will be considered an invalid request and will not be processed.

☐ I certify I cannot use the standard electric prior authorization transaction process because of a temporary technological or electrical failure.

Name: ______________________________________ Date: _____________

Michigan Prior Authorization
Request Form for Prescription Drugs

(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 ☐ _________________

☐ 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)

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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.

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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:____________	