

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)

<input type="checkbox"/> Standard Review Request
<input type="checkbox"/> Expedited Review Request: <i>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.</i> 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)

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: _____	

