AFREZZA®
PRIOR AUTHORIZATION REQUEST
PRESCRIBER FAX FORM

ONLY the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.
By submitting this form, you attest that all information provided is true and accurate.

PLEASE NOTE: Incomplete forms will be returned for additional information.
To ensure you are submitting this form correctly, you can complete and submit it directly to us online at www.covermymeds.com
For formulary information, please visit www.myprime.com

PATIENT AND INSURANCE INFORMATION **Today's date:** _____

Patient First Name:	Patient Last Name:	MI:	DOB (mm/dd/yyyy):
Patient Street Address:	City, State:	ZIP:	Patient Phone:
Member ID Number:	Group Number:		

PRESCRIBER/CLINIC INFORMATION

Prescriber First Name:	Prescriber Last Name:	NPI:	Specialty:
Clinic Name:	Contact Name:	Phone:	Secure Fax:
Clinic Street Address:	City, State:		ZIP:

RENDERING/SERVICING PRESCRIBER INFORMATION (IF APPLICABLE)

Prescriber First Name:	Prescriber Last Name:	NPI:	Specialty:
Clinic Name:	Contact Name:	Phone:	Secure Fax:
Clinic Street Address:	City, State:		ZIP:

MEDICAL INFORMATION. PLEASE ATTACH ADDITIONAL INFORMATION AS NEEDED.

Patient Diagnosis with ICD-9 Code:	ICD-10 Code:
Medication and Strength Requested:	
Dosing Schedule:	Quantity per Month:

ALL REQUESTS

Please list the medications the patient has previously tried and failed for the treatment of this diagnosis:

_____ Date range: _____ _____ Date range:_____
_____ Date range: _____ _____ Date range:_____
_____ Date range: _____ _____ Date range:_____

Is the patient currently treated with the requested agent? ..... ☐ Yes ☐ No

If yes: Did a prior health plan pay for the patient's medication during the 90 days immediately before this request? ..... ☐ Yes ☐ No

Does the patient have any FDA labeled contraindication(s) to the requested agent? ..... ☐ Yes ☐ No

If yes: Please provide contraindication(s): _____
_____

Please list all reasons for selecting the requested medication, dosing schedule, and quantity over alternatives (e.g. contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max): _____
_____
_____

Please continue to the next page.

Patient First Name:	Patient Last Name:	MI:	DOB (mm/dd/yyyy):

INITIAL REQUESTS

Does the patient have an intolerance, FDA labeled contraindication, or hypersensitivity to a preferred rapid acting insulin agent (Fiasp, Humalog, Humalog U200, Novolog) that is not expected to occur with the requested agent? ☐ Yes ☐ No

If no: Does the patient have a physical or mental disability that prevents them from using the preferred rapid acting insulin products (Fiasp, Humalog, Humalog U200, Novolog)? ☐ Yes ☐ No

If no: Does the patient have a documented needle phobia? ☐ Yes ☐ No

Please select the patient's diagnosis and answer all corresponding questions:

☐ **Diabetes mellitus type 1**

Is the patient currently on long acting insulin therapy? ☐ Yes ☐ No

☐ **Diabetes mellitus type 2**

☐ **Other:** _____

RENEWAL REQUESTS

Has the patient been previously approved for the requested agent through the plan's Prior Authorization process? ☐ Yes ☐ No

If no: Please also complete the Initial Requests section.

Has the patient had clinical benefit with the requested agent? ☐ Yes ☐ No

Please indicate:

☐ Date of service (if applicable): (mm/dd/yyyy): _____

☐ Start of treatment: Start date (mm/dd/yyyy): _____

☐ Continuation of therapy: Date of last treatment (mm/dd/yyyy): _____

What is the priority level of this request?

☐ Standard

☐ Urgent (NOTE: Urgent is defined as when the prescriber believes that waiting for a standard review could seriously harm the patient's life, health, or ability to regain maximum function.)

If yes: Please specify: _____

_____

Please fax or mail this form to:
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2900 Ames Crossing Road Suite 200
Eagan, MN 55121

TOLL FREE
FAX: 855.212.8110 PHONE: 888.271.3183