AFREZZA
PRIOR AUTHORIZATION REQUEST
PRESCRIBER FAX FORM

Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.

The following documentation is REQUIRED. Incomplete forms will be returned for additional information. For formulary information please visit *www.myprime.com*. Start saving time today by filling out this form electronically. Visit covermymeds.com to begin using this free service.

What is the priority level of this request?

☐ Standard review

☐ Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient's life, health or ability to regain maximum function

Today's Date: _____

PATIENT AND INSURANCE INFORMATION **Date of Service (if differs from Today's Date):** _____

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
Member ID Number:	Group Number:		

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Please select the patient's diagnosis:

☐ Diabetes mellitus (DM) Type 1

☐ Diabetes mellitus (DM) Type 2

☐ Other (ICD code, plus description): _____

Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:

For all requests:

1. Is the patient currently treated with the requested agent? ☐ Yes ☐ No
   If yes, is the patient currently stable on the requested agent? ☐ Yes ☐ No
2. Has the patient smoked in the past 6 months? ☐ Yes ☐ No
3. Does the patient have any FDA labeled contraindications to the requested agent? ☐ Yes ☐ No
   If yes, please specify FDA labeled contraindications: _____
   _____
4. Has the patient received ALL of the following to identify any potential lung disease: 1) detailed medical history review, 2) physical examination, and 3) spirometry with Forced Expiratory Volume in 1 second (FEV1)? ☐ Yes ☐ No
5. If the patient has diabetes mellitus (DM) Type 1, is the patient currently on long acting insulin therapy? ☐ Yes ☐ No
6. Is the patient's age within FDA labeling for the requested indication for the requested agent? ☐ Yes ☐ No
   If no, please provide support for using the requested agent for the patient's age for the requested indication: _____
   _____
7. Please list all reasons for selecting the requested agent for the indicated diagnosis, strength, dosing schedule, and quantity over alternatives (e.g., compendia support, journal articles, contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max). **Please note, documentation may be required:** _____
   _____
   _____

Please continue to the next page.

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

Preferred Agents	Non-Preferred Agents
Fiasp (insulin aspart) **Humalog** (insulin lispro) **Humalog U200** (insulin lispro) **Lyumjev** (insulin lispro-aabc) **Novolog** (insulin aspart)	**Admelog** (insulin lispro) **Apidra** (insulin glulisine) **Insulin aspart** **Insulin lispro**

8. Has the patient tried and had an inadequate response to ONE preferred agent? ☐ Yes ☐ No
9. Was ONE preferred agent discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? ☐ Yes ☐ No
10. Does the patient have an intolerance or hypersensitivity to ONE preferred agent that is not expected to occur with the requested agent? ☐ Yes ☐ No
    If yes, please explain intolerance/hypersensitivity:_____
    _____
11. Does the patient have an FDA labeled contraindication to ALL preferred agents that is not expected to occur with the requested agent? ☐ Yes ☐ No
    If yes, please specify FDA labeled contraindication: _____
    _____
12. Is ONE preferred agent expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; OR cause a significant barrier to the patient's adherence of care; OR worsen a comorbid condition; OR decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; OR cause an adverse reaction or cause physical or mental harm? ☐ Yes ☐ No
13. Is ONE preferred agent not in the best interest of the patient based on medical necessity? ☐ Yes ☐ No
14. Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as ONE preferred agent and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? ☐ Yes ☐ No
15. Is the requested agent medically necessary and appropriate for the patient? ☐ Yes ☐ No
16. Does the patient have a documented needle phobia? ☐ Yes ☐ No
17. Does the patient have a physical or a mental disability that would prevent them from using a preferred rapid acting insulin agent? ☐ Yes ☐ No
    If yes, please provide supporting information: _____
    _____

For renewal requests:

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

Please fax or mail this form to:
Prime Therapeutics LLC
Clinical Review Department
2900 Ames Crossing Road Suite 200
Eagan, MN 55121

TOLL FREE

Phone: **Fax: 877.243.6930**
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BCBSNM: 800.544.1378
BCBSOK: 800.991.5643
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