Prior Authorization Request Form for Afrezza

FAX this completed form to (877) 386-4695

OR Mail requests to: Envolve Pharmacy Solutions PA Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720

I. PROVIDER INFORMATION	II. MEMBER INFORMATION
Prescriber Name:	Member Name:
Prescriber Specialty:	Identification #:
Office Contact Name:	Group #:
Group Name:	Date of Birth:
Fax #:	Medication Allergies:
Phone #:	

III. DRUG INFORMATION (One drug request per form)		
Drug name and strength:	Dosage Interval (sig):	Qty. per Day:

IV. REQUIRED DOCUMENTION *(Detailed medical record documentation demonstrating evidence for each item must be submitted with prior authorization request)*

Specify diagnosis & diagnosis code relevant to this request: Dx/Dx Code: _____

Requests for all non-preferred medications: Does the member have a history of trial and failure of or contraindication or intolerance to the preferred Hypoglycemic Agents? *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred medications in this class.*	☐ Yes ☐ No	*Submit documentation of previous trials/failures, contraindications, and/or intolerances or current use.*

- ☐ Afrezza is prescribed by or in consultation with an endocrinologist
- ☐ Member does not have any contraindication to Afrezza
- ☐ Member does not have active lung cancer or a history of lung cancer
- ☐ Member has documented medical history of abstinence from smoking for at least 6 months and is not currently a smoker
- ☐ If requesting for daily quantity exceeding daily limit (Refer to https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/Quantity-Limits-and-Daily-Dose-Limits.aspx), please provide supporting information.

SUBMIT MEDICAL RECORD INFORMATION FOR EACH APPLICABLE ITEM.

AFREZZA:

- ☐ Documented history of therapeutic failure, contraindication or intolerance to short and rapid-acting injectable insulin: (medication, start date and end date)_____
- ☐ Member has been evaluated for lung function, including a documented detailed medical history, physical examination, and spirometry testing
- ☐ Member will be assessed for lung function using spirometry testing 6 months after initiating Afrezza and annually thereafter
- ☐ Documented baseline HbA1c:_____
- ☐ For type 1 diabetes mellitus, member will use Afrezza in conjunction with a long-acting insulin
- ☐ For type 2 diabetes mellitus, member failed to achieve glycemic control as evident by HbA1c despite using maximum tolerated dose of Metformin in combination with maximum tolerated second line agent used to treat type 2 diabetes in accordance with the most recent American Diabetes Association (ADA) guideline or
- ☐ For type 2 diabetes mellitus, member has a contraindication or intolerance to Metformin and the second line agent

AFREZZA RENEWAL REQUESTS:

- ☐ Documentation of most recent HbA1c
- ☐ Member has been evaluated 6 months after starting Afrezza and annually thereafter, if applicable
- ☐ Member has not experienced any bronchospasm, wheezing, or other respiratory difficulties after using Afrezza
- ☐ Member did not have a decline in FEV1 of >20% from baseline since starting Afrezza

IV. ADDITIONAL RATIONALE FOR REQUEST / PERTINENT CLINICAL INFORMATION :		
Appropriate clinical information to support the request on the basis of medical necessity must be submitted.	Provider Signature:	Date:

Envolve Pharmacy Solutions will respond via fax or phone within 24 hours.
Requests for prior authorization (PA) requests must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)