SENTARA HEALTH PLANS

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692.** No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is not complete, correct, or legible, authorization may be delayed.**

Drug Requested: Afrezza® (insulin human)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ Member must meet **ONE** of the following:
  - ❑ Member has a diagnosis of Type 1 diabetes
  - ❑ Member has a diagnosis of Type 2 diabetes
- ❑ Member is at least 18 years of age
- ❑ Member has tried and failed 30 days of therapy with Humalog® **(verified by chart notes and/or pharmacy paid claims)**
- ❑ Member does **NOT** currently smoke or has quit smoking within the past 6 months
- ❑ Member has **NOT** been diagnosed with chronic obstructive pulmonary disease (COPD)

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- ❑ Member has **NOT** been diagnosed with asthma
- ❑ Member has completed pulmonary function testing prior to initiation of therapy with requested medication
- ❑ Provider must submit member's baseline FEV_1: _____ Date: _____
- ❑ If treating **type 1 diabetes**: Member is on concomitant long-acting insulin therapy **(verified by chart notes and/or pharmacy paid claims)**
- ❑ If treating **type 2 diabetes**: Member has tried and failed 30 days of therapy with **at least 2 oral** antidiabetic medications **(provider please document antidiabetic therapies, verified by chart notes and/or pharmacy paid claims)**: _____; _____

Not all drugs may be covered under every Plan

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****