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:** __________________

DEA OR NPI #: ____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: ____

Dosing Schedule: ________________________ **Length of Therapy**: ________________

Diagnosis: ____________________________ **ICD Code, if applicable:** ______________

Weight: ____________________________ **Date:** ____________________________

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.

Check the indication that applies: ❑ **Type 1 diabetes** ❑ **Type 2 diabetes**

Initial Authorization Approval: Approval for six (6)months in length

- ❑ Patient has tried and failed 30 days of therapy with subcutaneous rapid acting insulin
  - ❑ Humalog®

  Patient is at least 18 years of age
- ❑ Patient currently smokes or has quit smoking within the past 6 months*
- ❑ Patient is diagnosed with chronic obstructive pulmonary disease (COPD)*
- ❑ Patient is diagnosed with asthma*
- ❑ Pulmonary function tests were completed* FEV_1: ________________ Date: ___________

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- ❑ If treating **type 1 diabetes**: patient is on concomitant long-acting insulin*
- ❑ If treating **type 2 diabetes**: patient has tried and failed 30 days of therapy with **at least 2 oral** antidiabetic medications: _______________________; _______________________

***Continuation of Approval - based on re-submission of above criteria and current spirometry results. Approval for one (1) year in length.**

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.****

***Approved by Pharmacy and Therapeutics Committee: 3/19/2015**
REVISED/UPDATED/REFORMATTED: ~~4/29/2015; 12/24/2015; 12/15/2016; 8/19/2017; (Reformatted) 5/28/2019;~~ **6/15/2020**