

AvMed

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 1-305-671-0200**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Afrezza® (insulin human)

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

Member Name: _____

Member AvMed #: _____ 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 6 years of age or older
- ☐ 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 FEV₁: _____ 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.****