OPTIMA HEALTH PLAN

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)

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

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

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

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: _____
- ❑ 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.**

(Continued on next page; signature page is required to process request.)

(Please ensure signature page is attached to form.)

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.****

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

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