

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: _____

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)*

(Continued on next page)

- Patient is diagnosed with asthma*
- Pulmonary function tests were completed* FEV₁: _____ 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.**

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.