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. Incomplete form will delay authorization process.***

Drug Requested: **Afrezza**® (insulin human)

DRUG INFORMATION: Complete information below. If incomplete, authorization process will be delayed.

Drug Form/Strength: _____

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

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

CLINICAL CRITERIA: ALL boxes must be checked to qualify or authorization process will be delayed. Chart notes (documentation) of failure MUST be attached to request.

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® ❑ Apidra® ❑ Novolog®	❑ Yes	❑ No
Patient is at least 18 years of age	❑ Yes	❑ No
Patient currently smokes or has quit smoking within the past 6 months*	❑ Yes	❑ No
Patient is diagnosed with chronic obstructive pulmonary disease (COPD)*	❑ Yes	❑ No
Patient is diagnosed with asthma*	❑ Yes	❑ No
Pulmonary function tests were completed* ❑ FEV_1: _____ Date: _____	❑ Yes	❑ No
If treating **type 1 diabetes**: patient is on concomitant long acting insulin*	❑ Yes	❑ No
If treating **type 2 diabetes**: patient has tried and failed 30 days of therapy with ***at least 2 oral*** antidiabetic medications: _____; _____	❑ Yes	❑ No

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

*****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~~; **9/19/2017**