Prior Authorization Request Form for
insulin [oral inhalation] **(Afrezza)**

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. Is the patient a smoker?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question 2
2. Does the patient have a contraindication to the use of Afrezza or will it be used during episodes of hypoglycemia? *(Contraindications include chronic lung disease, such as asthma or COPD [chronic obstructive pulmonary disease], hypersensitivity to regular human insulin or any of the Afrezza inactive ingredients.)*	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question 3
3. What is the indication or diagnosis?	☐ Type 1 diabetes mellitus – Proceed to question 4 ☐ Type 2 diabetes mellitus – Proceed to question 5 ☐ Other indication or diagnosis – **STOP – Coverage not approved**	
4. Is Afrezza being added to current basal insulin therapy?	☐ Yes **SKIP** to question **7** **on page 2**	☐ No **STOP** **Coverage not approved**
5. Does the patient have a contraindication to metformin?	☐ Yes Proceed to question 6	☐ No **STOP** **Coverage not approved**
6. Has the patient failed therapy or had a clinically significant adverse effect to two oral anti-diabetic agents? *(Examples of oral anti-diabetes drug classes include sulfonylureas, thiazolidinediones [TZD], DPP-4 inhibitors [dipeptidyl peptidase-4 inhibitors], etc.)*	☐ Yes **SKIP** to question **7** **on page 2**	☐ No **STOP** **Coverage not approved**

continue to Page 2

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7. Has the patient failed to achieve a hemoglobin A1C of 7% or less in 90 days of use of a rapid or short-acting subcutaneous (SC) insulin product?	☐ Yes **SKIP** to question **9**	☐ No Proceed to question 8
8. Has the patient experienced a clinically significant adverse effect with subcutaneous (SC) rapid or short-acting insulin that is not expected to occur with inhaled insulin?	☐ Yes Proceed to question 9	☐ No **STOP** **Coverage not approved**
9. Will baseline spirometry testing be performed on initiation of therapy that includes forced expiratory volume in the first second (FEV1)?	☐ Yes Proceed to question 10	☐ No **STOP** **Coverage not approved**
10. Will FEV1 spirometry testing be repeated 6 months after starting therapy and repeated annually thereafter?	☐ Yes Sign and date below	☐ No **STOP** **Coverage not approved**

Step 3

I certify the above is true to the best of my knowledge. Please sign and date:

_____ _____

Prescriber Signature Date

[10 August 2016]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: