

Prior Authorization Request Form for  
**Brensocatib (Brinsupri)**



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.

Prior authorization does not expire.

**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 12 years of age or older?	<input type="checkbox"/> Yes Proceed to question 2	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
2. Is the requested medication being prescribed by a pulmonologist?	<input type="checkbox"/> Yes Proceed to question 3	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
3. What is the indication or diagnosis?	<input type="checkbox"/> Non-cystic fibrosis bronchiectasis confirmed by CT scan – Proceed to question 4 <input type="checkbox"/> Other diagnosis – <b>STOP – Coverage not approved</b>	
4. Are respiratory symptoms treated with brensocatib primarily due to comorbid asthma or COPD?	<input type="checkbox"/> Yes <b>STOP</b> Coverage not approved	<input type="checkbox"/> No Proceed to question 5
5. Has the patient had at least 2 exacerbations in the past 12 months requiring an antibiotic?	<input type="checkbox"/> Yes Proceed to question 6	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
6. Does the patient have cystic fibrosis?	<input type="checkbox"/> Yes <b>STOP</b> Coverage not approved	<input type="checkbox"/> No Proceed to question 7
7. Does the patient require oxygen for more than 12 hours per day?	<input type="checkbox"/> Yes <b>STOP</b> Coverage not approved	<input type="checkbox"/> No Proceed to question 8

Prior Authorization Request Form for  
**Brensocatib (Brinsupri)**

8. Is the patient currently smoking?

Yes

No

**STOP**

Coverage not approved

Sign and date below

**Step 3** I certify the above is true to the best of my knowledge. Please sign and date:

\_\_\_\_\_  
Prescriber Signature

\_\_\_\_\_  
Date

[26 August 2025]

**For Internal Use Only**

Approved:

Duration of Approval: \_\_\_\_month(s)

Denied:

Authorized By:

Incomplete/Other:

PA#:

Date Faxed to MD:

Date Decision Rendered: