TRICARE Prior Authorization Request Form for
ensifentrine **(Ohtuvayre)**

JOHNS HOPKINS
HEALTH PLANS

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.

Initial approvals expire after twelve months, renewal approvals are indefinite. For renewal of therapy an initial Tricare prior authorization approval is required.

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. Has the patient received this medication under the TRICARE benefit in the last 6 months? ***Please choose "No" if the patient did not previously have a TRICARE approved PA for Ohtuvayre.***	☐ Yes (subject to verification) Proceed to question **2**	☐ No Proceed to question **3**
2. **Has the patient's disease severity improved and stabilized to warrant continued therapy?**	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
3. **Is the patient 18 years of age or older?**	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. **Is the requested medication prescribed by or in consultation with a pulmonologist?**	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. **What is the indication or diagnosis?**	☐ Chronic obstructive pulmonary disease (COPD) - Proceed to question **6** ☐ Other diagnosis – **STOP Coverage not approved**	
6. **Does the patient have moderate to severe COPD airflow obstruction as demonstrated by FEV1 (forced expiratory volume 1 second) that is between 30 to 80% of the predicted value?**	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**

Question	Yes	No
7. Has the patient tried and failed, defined as uncontrolled symptoms, with either of the following treatments: • **LAMA/LABA (Bevespi Aerosphere, Stiolto Respimat, Anoro Ellipta) OR** • **LAMA/LABA/ICS (Breztri Aerosphere, Trelegy Ellipta)?**	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. Will the requested medication only be used as add on therapy to LAMA/LABA or LAMA/LABA/ICS?	☐ 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

[12 February 2025]

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