

# 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.*

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

- Afrezza® is rapid acting insulin indicated to improve glycemic control in adult patients with diabetes mellitus.
- Afrezza® should not be used in patients who smoke or to treat diabetic ketoacidosis.
- Afrezza® should be administered at the beginning of meals, via oral inhalation. Dosing must be individualized.
- Before initiating, perform a detailed medical history, physical examination, and spirometry (FEV<sub>1</sub>) in all patients to identify potential lung disease.
- **Boxed Warning:** Afrezza® is contraindicated in patients with chronic lung disease such as asthma or COPD
- Type 1 diabetes: must be used with long-acting insulin

**Indication:** (please check the indication that applies)

Type 1 diabetes

Type 2 diabetes

**Please complete all boxes below:** for original authorization (continued authorization see below)

Patient has tried and failed 30 days of therapy with subcutaneous rapid acting insulin <input type="checkbox"/> Humalog® <input type="checkbox"/> Apidra® <input type="checkbox"/> Novolog® (documentation (chart notes) of failure must be attached)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Patient is at least 18 years of age	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Patient currently smokes or has quit smoking within the past 6 months*	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Patient is diagnosed with chronic obstructive pulmonary disease (COPD)*	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Patient is diagnosed with asthma*	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pulmonary function tests were completed * <input type="checkbox"/> FEV <sub>1</sub> : _____ Date: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If treating <b>type 1 diabetes:</b> patient is on concomitant long acting insulin*	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If treating <b>type 2 diabetes:</b> patient has tried and failed 30 days of therapy with at least 2 oral antidiabetic medications: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Afrezza® causes a decline in lung function over time as measured by FEV<sub>1</sub>. Assess pulmonary functioning at baseline, 6 months of therapy, and annually thereafter, even in the absence of pulmonary symptoms. Discontinuation should be considered in patients with a decline of ≥ 20% of FEV<sub>1</sub> from baseline.

--- LENGTH OF ORIGINAL AUTHORIZATION IS 6 MONTHS ---

\***CONTINUED APPROVAL** (1 YEAR IN LENGTH) IS BASED ON RE-SUBMISSION OF ABOVE CRITERIA AND CURRENT SPIROMETRY RESULTS.

**\*PAID transaction(s) will be verified through Pharmacy claims.\***

Patient Name: \_\_\_\_\_

Member Optima #: \_\_\_\_\_ Member Date of Birth: \_\_\_\_\_

Prescriber Name: \_\_\_\_\_

Prescriber Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

DEA/NPI #: \_\_\_\_\_