BlueCross BlueShield Federal Employee Program

AFREZZA
PRIOR APPROVAL REQUEST

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Additional information is required to process your claim for prescription drugs. Please complete the cardholder portion, and have the prescribing physician complete the physician portion and submit this completed form.

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: Male Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: R			Physician Signature:		
PHYSICIAN COMPLETES					

Afrezza

(insulin human)

***Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

Is this request for brand or generic? ❑ Brand ❑ Generic

1. What is the patient's diagnosis?

❑ Diabetes mellitus Type 1

a. Will the Afrezza be used in combination with a long-acting insulin therapy? ❑Yes ❑No

b. Will the Afrezza be used in combination with an insulin pump? ❑Yes ❑No

❑ Diabetes mellitus Type 2

❑ Other diagnosis ***(please specify)***: _____

2. Has the patient been receiving Afrezza therapy for at least **4 months** continuously, excluding samples? ***Select answer below:***

❑ **NO** – this is **INITIATION** of therapy, please answer the following questions:

a. Has the patient had an inadequate response, intolerance, or contraindication to one of the prior therapies below?

❑ **Type 1 Patient:** Rapid or short-acting subcutaneous insulin product? ❑Yes ❑No

❑ **Type 2 Patient:** Oral anti-diabetic agent? ❑Yes ❑No

b. Will the patient have spirometry testing before initiating therapy, after 6 months of therapy and then annually? ❑Yes ❑No

c. Does the patient have a FEV^1 greater than or equal to 70% ? ❑Yes ❑No

d. Is the patient a non-smoker or is in a smoking cessation program? ❑Yes ❑No

e. Does the patient have a history of chronic lung disease, such as asthma or COPD? ❑Yes ❑No

f. Does the patient have active lung cancer? ❑Yes ❑No

g. Is Afrezza being used for the treatment of diabetic ketoacidosis? ❑Yes ❑No

❑ **YES –** this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:

a. Will spirometry testing be done annually? ❑Yes ❑No

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Message:

Attached is a Prior Authorization request form.

For your convenience, there are 3 ways to complete a Prior Authorization request:

Electronically Online (ePA) Results in 2-3 **minutes** **FASTEST AND EASIEST**	Now you can get responses to drug prior authorization requests **securely** online. **Online** submissions may receive **instant** responses and do not require faxing or phone calls. Requests can be made 24 hours a day, 7 days a week. For more information on electronic prior authorization (ePA) and to register, go to **Caremark.com/ePA.**
Phone (4-5 **minutes** for response)	The FEP Clinical Call Center can be reached at **(877)-727-3784** between the hours of 7AM-9PM Eastern Time. A live representative will assist with the Prior Authorization, asking for the same info contained on the attached form. Please review the form and have your answers ready for faster service. The process over the phone takes on average between 4 and 5 minutes.
Fax (3-5 **days** for response)	Fax the attached form to **(877)-378-4727** Requests sent via fax will be processed and responded to within 5 business days. The form must be filled out completely, if there is any missing information the PA request cannot be processed. ***Please only fax the completed form once as duplicate submissions may delay processing times.***

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification:** I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer. Afrezza – FEP CSU_MD Fax Form Revised 7/17/2020