

physician portion and submit this completed form

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 patient portion, and have the prescribing physician complete the

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	1 1			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. Does the patient have a diagnosis of diabetes mellitus type 1 or diabetes mellitus type 2? □Yes* □No **If YES*, please select one of the following: □Diabetes mellitus Type 1 <u>OR</u> □Diabetes mellitus Type 2
- 2. Diabetes Mellitus Type 1 Diagnosis: Please answer the following questions:
 - a. Will this medication be used in combination with a long-acting insulin therapy? \Box Yes \Box No
 - b. Will this medication be used in combination with an insulin pump? \Box Yes \Box No
- 3. Has the patient been on this medication continuously for the last **4 months** excluding samples? *Please select answer below:* \Box **NO** this is **INITIATION** of therapy, please answer the following questions:
 - a. Will the patient have spirometry testing before initiating therapy, after 6 months of therapy and then annually? Tyes INO
 - b. Is the patient a non-smoker or is in a smoking cessation program? **U**Yes **U**No
 - c. Does the patient have a history of chronic lung disease, such as asthma or COPD? The The Section 2015 the section of the se
 - d. Will this medication be used for the treatment of diabetic ketoacidosis? Yes No
 - e. Does the patient have active lung cancer? Yes No
 - f. Does the patient have a FEV1 greater than or equal to 70% of predicted value ? □Yes □No
 - g. Diabetes Mellitus Type 1 Diagnosis: Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to one rapid- or short-acting subcutaneous insulin product? □Yes □No
 - h. **Diabetes Mellitus Type 2 Diagnosis**: Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to an oral anti-diabetic agent **AND** long-acting insulin therapy? \Box Yes \Box 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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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 information 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 Prior Authorization request cannot be processed. <u>Please only fax the completed form once as</u> <u>duplicate submissions may delay processing</u> <u>times.</u>

faster	Introducing ePA! Online Prior
easier	Authorizations in minutes through
easier	Caremark.com/ePA. Sign up today!
better	
	CVS/caremark [®]

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 – FP MD Fax Form Revised 4/19/2024