

USFHP Prior Authorization Request Form for
insulin [oral inhalation] **(Afrezza)**

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:

Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? Call 1-877-880-7007

<https://www.usfamilyhealth.org/for-providers/pharmacy-information/>

Clinical documentation may be 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. Is the patient a smoker?	☐ Yes STOP Coverage not approved	☐ No Proceed to question 2
2. Does the patient have a contraindication to the use of Afrezza or will it be used during episodes of hypoglycemia? <i>(Contraindications include chronic lung disease, such as asthma or COPD [chronic obstructive pulmonary disease], hypersensitivity to regular human insulin or any of the Afrezza inactive ingredients.)</i>	☐ Yes STOP Coverage not approved	☐ No Proceed to question 3
3. Insulin aspart (Novolog) and insulin lispro (Humalog or authorized generic insulin lispro) are the Department of Defense's preferred rapid acting insulin. The preferred products do not require prior authorization.	☐ Acknowledged Proceed to question 4	
4. Has the patient tried and failed (defined as a failure to achieve hemoglobin A1c $\leq$ 7 % in 90 days) with insulin aspart (Novolog)?	☐ Yes Proceed to question 5	☐ No STOP Coverage not approved
5. Has the patient tried and failed (defined as a failure to achieve hemoglobin A1c $\leq$ 7 % in 90 days) with insulin lispro (Humalog or authorized generic insulin lispro)?	☐ Yes Proceed to question 6	☐ No STOP Coverage not approved
6. What is the indication or diagnosis?	☐ Type 1 diabetes mellitus – Proceed to question 7 ☐ Type 2 diabetes mellitus – Proceed to question 8 ☐ Other indication or diagnosis – STOP – Coverage not approved	
7. Is Afrezza being added to current basal insulin therapy?	☐ Yes Proceed to question 11	☐ No STOP Coverage not approved

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8. Has the patient failed therapy or had a clinically significant adverse effect to metformin?	☐ Yes Proceed to question 11	☐ No Proceed to question 9
9. Does the patient have a contraindication to metformin?	☐ Yes Proceed to question 10	☐ No STOP Coverage not approved
10. Has the patient failed therapy or had a clinically significant adverse effect to two oral anti-diabetic agents? <i>(Examples of oral anti-diabetes drug classes include sulfonylureas, thiazolidinediones [TZD], DPP-4 inhibitors [dipeptidyl peptidase-4 inhibitors], or SGLT2 inhibitor).</i>	☐ Yes Proceed to question 11	☐ No STOP Coverage not approved
11. Will baseline spirometry testing be performed on initiation of therapy that includes forced expiratory volume in the first second (FEV1)?	☐ Yes Proceed to question 12	☐ No STOP Coverage not approved
12. Will FEV1 spirometry testing be repeated 6 months after starting therapy and repeated annually thereafter?	☐ Yes Sign and date below	☐ No STOP Coverage not approved

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

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Prescriber Signature

Date

[01 July 2020]