US Family Health Plan

Prior Authorization Request Form for

Ensifentrine (Ohtuvayre)

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**

Clinical documentation may be required. Failure to provide could result in denial.

Prior authorization does not expire.

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 18 years of age or older?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Is the requested medication prescribed or in consultation with pulmonologist?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Does the patient have a diagnosis of chronic obstructive pulmonary disease (COPD)?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Does the patient have moderate to severe disease (for example, GOLD 2 [moderate] or GOLD 3 [severe] airflow obstruction, as demonstrated by and FEV 1 (forced expiratory volume 1) that is greater than or equal to 30% and less than 80% of the predicted value.)? Note: GOLD airflow obstruction refers to the classification of COPD severity based on the Global Initiative for Chronic Obstructive Lung Disease (GOLD) guidelines.	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Does the prescriber affirm that ensifentrine is only to be used as add on therapy to one of the following inhaler: LAMA, LABA, LAMA/LABA, or LAMA/LABA/ICS (long-acting muscarinic antagonist / long-acting beta agonist / inhaled corticosteroids)?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

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Step 3	**I certify the above is true to the best of my knowledge.** Please sign and date:

Prescriber Signature _____ Date _____

[8 Aug 2024]