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**

Initial approvals expire after twelve months, renewal approvals are indefinite. For renewal of therapy an initial Tricare prior authorization approval is 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. Has the patient received this medication under the TRICARE benefit in the last 6 months? ***Please choose "No" if the patient did not previously have a TRICARE approved PA for Ohtuvayre.***	☐ Yes (subject to verification) Proceed to question **2**	☐ No Proceed to question **3**
2. Has the patient's disease severity improved and stabilized to warrant continued therapy?	☐ Yes **Sign and date below**	☐ No **STOP Coverage not approved**
3. Is the patient 18 years of age or older?	☐ Yes Proceed to question **4**	☐ No **STOP Coverage not approved**
4. Is the requested medication prescribed by or in consultation with a pulmonologist?	☐ Yes Proceed to question **5**	☐ No **STOP Coverage not approved**
5. What is the indication or diagnosis?	☐ Chronic obstructive pulmonary disease (COPD) - Proceed to question **6** ☐ Other diagnosis – **STOP Coverage not approved**	
6. Does the patient have moderate to severe COPD airflow obstruction as demonstrated by FEV1 (forced expiratory volume 1 second) that is between 30 to 80% of the predicted value?	☐ Yes Proceed to question **7**	☐ No **STOP Coverage not approved**

7. Has the patient tried and failed, defined as uncontrolled symptoms, with either of the following treatments: • **LAMA/LABA (Bevespi Aerosphere, Stiolto Respimat, Anoro Ellipta) OR** • **LAMA/LABA/ICS (Breztri Aerosphere, Trelegy Ellipta)?**	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. Will the requested medication only be used as add on therapy to LAMA/LABA or LAMA/LABA/ICS?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3

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

Prescriber Signature _____ Date _____

[12 February 2025]