OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Afrezza® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:
❑ Type 1 diabetes mellitus
❑ Type 2 diabetes mellitus
❑ Other diagnosis: ____________________________ ICD-10 Code(s): ___________________________________

Select the medications the patient has a failure, contraindication, or intolerance to:
❑ Admelog SoloStar
❑ Apidra SoloStar
❑ Fiasp FlexTouch
❑ Humalog cartridge
❑ Humalog Junior KwikPen
❑ Humalog KwikPen
❑ Humalog vial
❑ Novolog FlexPen
❑ Novolog PenFill
❑ Novolog vial

Clinical Information:

Does the patient have a documented Forced Expiratory Volume in 1 second (FEV1) within the last 60 days greater than or equal to 70% of expected normal as determined by the physician? ❑ **Yes** ❑ **No**

Does the patient smoke cigarettes? ❑ **Yes** ❑ **No**

Has the patient recently quit smoking (within the past 6 months)? ❑ **Yes** ❑ **No**

Does the patient have chronic lung disease (e.g., asthma, chronic obstructive pulmonary disease [COPD])? ❑ **Yes** ❑ **No**

Was Afrezza prescribed by or in consultation with an endocrinologist? ❑ **Yes** ❑ **No**

For type 1 diabetes mellitus, in addition to the above, answer the following:
Will Afrezza be used in combination with a long acting insulin (e.g., Lantus, Levemir)? ❑ **Yes** ❑ **No**

Reauthorization:
If this is a reauthorization request, answer the following questions:

Has the patient experienced a decline of 20% or more in FEV1 from baseline that was confirmed by a repeat pulmonary function test after the first 6 months of therapy? ❑ **Yes** ❑ **No**

Is there documentation of positive clinical response to Afrezza therapy? ❑ **Yes** ❑ **No**

Does the patient have chronic lung disease (e.g., asthma, chronic obstructive pulmonary disease [COPD])? ❑ **Yes** ❑ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

____

Please note: This request may be denied unless all required information is received.
If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of OptumRx. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**
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