Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Afrezza Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 12 months; Continuation- 12 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Afrezza.** Please complete all sections, incomplete forms will delay processing. Fax this form back to Kaiser Permanente within 24 hours fax: 1-866-331-2104. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless all sections are complete.**

KP-MAS Formulary can be found at: http://www.providers.kaiserpermanente.org/mas/formulary.html

1 – Patient Information

Patient Name: ______________________________ Kaiser Medical ID#: _________________ Date of Birth: _____________

2 – Prescriber Information

Prescriber Name: ______________________________ Specialty: ____________________________ NPI: _________________

Prescriber Address: ____

Prescriber Phone #: __________________________Prescriber Fax #: ___________________________

3 – Pharmacy Information

Pharmacy Name: ________________________________ Pharmacy NPI: ____

Pharmacy Phone #_______________________________ Pharmacy Fax #: ____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: ____

Sig: ____

Drug 2: Name/Strength/Formulation: ____

Sig: ____

5– Diagnosis/Clinical Criteria

1. Is this request for initial or continuing therapy?
   □ Initial therapy □ Continuing therapy, State date: _________________________
2. Indicate the patient's diagnosis for the requested medication: ______________________________________

3. Does the member have a diagnosis of type 1 diabetes mellitus, **AND**
   □ No □ Yes

4. Is being used in combination with a basal insulin or continuous insulin pump, **OR**
   □ No □ Yes

5. Has a diagnosis of type 2 diabetes mellitus, **AND**
   □ No □ Yes

6. Member is unable to self-inject due to physical impairment OR visual impairment OR lipohypertrophy, **AND**
   □ No □ Yes

7. FEV1 within the last 60 days is greater than or equal to 70% of expected, **AND**
   □ No □ Yes

8. Member is not a smoker OR has quit smoking in the last 6 months, **AND**
   □ No □ Yes

9. Member does not have chronic lung disease (asthma, COPD)
   □ No □ Yes

For continuation of therapy, please respond to additional questions below.

1. Repeat pulmonary function test confirms that member has NOT experienced a decline of 20% or more in FEV1, **AND**
   □ No □ Yes

2. Member continues to be unable to self-inject due to physical impairment OR visual impairment **OR** lipohypertrophy
   □ No □ Yes

3. Must continue to meet inclusion criteria?
   □ No □ Yes

6 – Prescriber Sign-Off

Additional Information – Please submit chart notes/medical records for the patient that are applicable to this request. If no to any of the above questions, please provide any additional supporting information that should be taken into consideration:

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I certify that the information provided is accurate. Supporting documentation is available for State audits.

Prescriber Signature:	**Date:**

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