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:

_____

_____

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

Prescriber Signature:	**Date:**