AFREZZA ®
PRIOR AUTHORIZATION
Physician Fax Form

BCBS Kansas REQUIRES that this form be completed by the prescriber. This form is for prospective, concurrent and retrospective reviews.

The following documentation is REQUIRED for prior authorization. Incomplete forms will be returned for additional information.
To ensure you are submitting this form correctly, you can complete and submit it directly to us online at www.covermymeds.com
For formulary information, please visit the Blue Cross and Blue Shield of Kansas website at http://www.bcbsks.com

PATIENT INFORMATION **Today's Date:** ______________

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
Member ID Number:	Group Number:		

PHYSICIAN/CLINIC INFORMATION

Prescriber Name:	Physician NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient's Diagnosis (ICD code plus description):

Medication Requested: Strength:

Dosing Schedule: Quantity per Month:

1. Is the patient currently treated with the requested medication? .... ☐ Yes ☐ No
   If yes, when was treatment with the requested medication started? ______________
2. Has the patient smoked in the past 6 months? .... ☐ Yes ☐ No
3. Does the patient have a physical or mental disability that prevents them from using the preferred rapid acting insulin products? .... ☐ Yes ☐ No
   If yes, please explain ______________
4. Has the patient received any of the following to identify potential lung problems? (check ALL that apply)
   ☐ Detailed medical history review ☐ Physical examination ☐ Spirometry with Forced Expiratory Volume in 1 second (FEV1)
5. Does the patient have chronic lung disease (e.g. asthma, chronic obstructive pulmonary disease)? .... ☐ Yes ☐ No
6. Please list the medications the patient has **previously tried and failed for treatment of this diagnosis** (Please specify if brand name, generic, extended-release products or OTC products)**:**

   ______________ Date: ________ ______________ Date: ________
   ______________ Date: ________ ______________ Date: ________
   ______________ Date: ________ ______________ Date: ________
7. Please list all reasons for selecting the **requested medication** over alternatives (e.g. contraindications, risk of losing good glucose control, allergies or history of adverse drug reactions.) ______________
8. Please list all other medications the patient is **currently taking** for treatment of this diagnosis. ______________

Please fax or mail this form to:
Prime Therapeutics LLC
Clinical Review Department
1305 Corporate Center Drive
Eagan, Minnesota 55121

TOLL FREE

Fax: 877.480.8130 **Phone: 866.469.5660**

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