

Fax completed form to: 1-866-868-0858
Questions, please call: 1-866-316-6049

Avera Advantage™

Important Information About Prescription Drug Coverage

To: _____ From: _____

Fax: _____ Pages: _____

Re: Exubera® (Insulin Inhalation): Prior Authorization Request Form: Please respond.

- Please complete the attached Exubera® (Insulin Inhalation) Prior Authorization Request Form
- To expedite the review process please complete all requested fields.
- Completed forms should be faxed to: 1-866-868-0858. It is not necessary to fax this cover page.

Please note: By signing the attached form you are certifying that the treatment requested is medically necessary. No contraindications are present and precautions have been considered. You will be supervising the patient's treatment. Supporting documentation is available in the patient's record. Signature on this form attests to the fact that the corresponding ICD-9 code has been documented in the patients chart and submitted on a CMS- 1500 form.

Information about this drug

Exubera® (Insulin Inhalation)

Exubera® is not recommended for use in asthma, COPD, smokers and various other lung diseases. The efficacy and safety in patients with baseline FEV1 or carbon monoxide diffusing capacity <70% predicted has not been established and is not recommended. Assessment of pulmonary function is recommended at baseline, after the first 6 months of therapy, and annually thereafter. Patients with a decline of > or = to 20% in FEV1 from baseline should discontinue therapy.

You can make an expedited request by indicating this at the top of the attached form. If you request an expedited review, and sign the attached form, you certify that applying the 72 hour standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

Information on the attached form is protected health information and subject to all privacy and security regulations under HIPAA.

Prior Authorization Request Form

Avera Advantage™

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Patient Information

Name _____
Member ID _____
Medicare ID _____
Date of birth _____ Sex: M / F
Address _____
City _____
State _____ ZIP _____
Phone _____
Nursing home resident? YES / NO
Home care patient? YES / NO

Prescriber and Pharmacy Information

Name _____
Specialty _____
DEA _____
NPI _____
Address _____
City _____
State _____ ZIP _____
Phone _____ Fax _____
Pharmacy name _____
NCPDP _____
NPI _____
Phone _____ Fax _____

All items below this line are for Physician Use Only

Information for Requested Drug

Strength: _____ Dosage form: _____ Qty per 30 days: _____ Drug is (circle one): Newly prescribed/Refill
Directions: _____ Diagnosis: _____ ICD-9 Code: _____

Standard Reviews will be completed in under 72 hours. An expedited review is available if you certify that a standard review timeframe will seriously jeopardize the health of your patient. To request an expedited review, simply indicate this at the top of this page.

Exubera® (Insulin Inhalation) Criteria

- Please indicate classification of diabetes mellitus:
 Type I Type II 30 or more days for each drug or both in combination?
 Yes No
- Please specify the diagnosis code(s) supporting the necessity for the requested agent. This question must be completed.
 ICD-9: _____
- Is the patient's HGBA1c > or = to 8%?
 Yes No
- Does the patient have unstable or poorly controlled lung disease (e.g., asthma, COPD)
 Yes No
- Is the patient a smoker or has discontinued smoking less than 6 months ago?
 Yes No
- Is the patient's baseline FEV1 or carbon monoxide diffusing capacity <70% predicted?
 Yes No
- For patients with Type II diabetes: Has the patient failed to receive a clinically appropriate therapeutic response OR demonstrated intolerance (e.g., allergy, hypersensitivity, adverse effects, development of a contraindication) from both metformin AND a sulfonylurea (e.g., glipizide, glyburide) over a period of

Medical justification: (Attach additional page if necessary): _____

Prescriber's signature: _____ Date: _____