BlueCross BlueShield
Federal Employee Program

Afrezza
PRIOR APPROVAL REQUEST

Send completed form to:
Blue Shield of California
Fax: 1-855-895-3504

Additional information is required to process your claim for prescription drugs. Please complete the cardholder portion, and have the prescribing physician complete the physician portion and submit this completed form. All incomplete and illegible forms will be returned to the patient.

CARDHOLDER / PATIENT INFORMATION

Cardholder Name: _____ / _____ / _____
First MI Last

Patient Name: _____ / _____ / _____
First MI Last

Patient Address: _____
Street City State Zip

Patient Date of Birth: ____ / ____ / ____ Sex: M ____ F ____

R _____
Cardholder Identification Number

PHYSICIAN COMPLETES

Afrezza

NOTE: Form must be completed in its **entirety** for processing

1. What is the patient's **diagnosis?**
   - ❑ **Diabetes mellitus Type 1**
     a. Will the Afrezza be used in combination with a long-acting (basal) insulin therapy? ❑Yes ❑No
   - ❑ **Diabetes mellitus Type 2**
   - ❑ **Other diagnosis** ***(please specify):*** _____

2. Has the patient been receiving **Afrezza** therapy for at least **4 months** continuously, excluding samples?

❑**NO** – this would be the **INITIATION** of Afrezza therapy, please answer **the following** questions:

a. Has the patient had an inadequate response, intolerance, or contraindication to one prior therapy of:
Type 1 patients: rapid or short-acting subcutaneous insulin product? ❑Yes ❑No
Type 2 patients: oral anti-diabetic agent? ❑Yes ❑No

b. Will the patient have spirometry testing before initiating therapy, after 6 months of therapy, and then annually? ❑Yes ❑No

c. Does the patient have a FEV^1 greater than or equal to 70 mL? ❑Yes ❑No

d. Is the patient a non-smoker or is in a smoking cessation program? ❑Yes ❑No

e. Does the patient have a history of chronic lung disease, such as asthma or COPD? ❑Yes ❑No

f. Does the patient have active lung cancer? ❑Yes ❑No

g. Is Afrezza being used for the treatment of diabetic ketoacidosis? ❑Yes ❑No

❑**YES –** this would be the **CONTINUATION of therapy**, please answer **the following** question:

a. Will spirometry testing be done annually? ❑Yes ❑No

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification.
Prescriber Certification: I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer.

_____ (_____) _____ (_____) _____
Physician Name (Print Clearly) Phone Fax

_____ _____ _____ _____
Street Address City State Zip

_____ _____ _____ / _____ / _____
Prescriber's NPI Physician Signature Date