AmeriHealth Caritas New Hampshire

Inhaled Insulin Medications

Prior Authorization Drug Approval Form

Date of medication request: (MM/DD/YYYY): ____ / ____ / _____

Patient information and medication requested	
Patient's name:	Medicaid number:
Date of birth:	Gender:
Drug name:	Strength:
Dosing directions:	Length of therapy:

Prescriber information			
Prescriber last name:		Prescriber first name:	
Prescriber address:		Prescriber representative:	
NPI number:		Specialty:	
Phone #:	Fax #:		

Clinical history
1. Please list recent FEV1 level and date taken:
2. Does patient have concurrent diagnosis of COPD, asthma, or emphysema? ☐ Yes ☐ No
3. Is the patient an active cigarette smoker? ☐ Yes ☐ No If no to question 3, list date of last cigarette smoked:
4. Does the patient have a diagnosis of Type 1 diabetes? ☐ Yes ☐ No If yes to question 4, has the patient had a history of treatment failure with fast acting SC insulin? ☐ Yes ☐ No If yes to question 4, will the patient be on concurrent use of a long acting insulin? ☐ Yes ☐ No
5. Does the patient have a diagnosis of Type 2 diabetes? ☐ Yes ☐ No If yes to question 5, please provide patient's HgA1C: If yes to question 5, has the patient had a history of treatment failure with fast acting SC insulin? ☐ Yes ☐ No If yes to question 5, list maximum doses of sulfonylureas, metformin, and TZDs:
Provide any additional information that would help in the decision-making process. If additional space is needed, please use a separate sheet.

Signature of prescriber:_____ Date: _____
(prescriber signature mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.