CloudTop Health

PRIOR AUTHORIZATION REQUEST

REQUEST ID:

Patient Information:	**Request Information:**
Patient:	Drug:
Phone:	Prescriber:
Address:	Pharmacy:
	Contact:

Hello,

The patient's insurance requires prior authorization for this prescription. If you would like us to submit and follow up on the request, **please complete:**

- **Section 1 - Authorization Request**
- **Section 2 - Afrezza Questionnaire**
- **Include the following information:**
  - **Patient Demographics**
  - **Insurance**
  - **Medication List**
  - **Patient Chart Notes including clinical justification for Afrezza**

Please fax Sections 1 and 2 along with a copy of the items above to **(866)-588-0371** or via our online portal **https://cloudtophealth.com/**.

Sincerely,
CloudTop Health

SECTION 1 – AUTHORIZATION REQUEST (Check Box Below)

☐ **Authorize CloudTop Health to submit the request**

☐ Electronic Prescription Has Been Sent to Sterling Specialty Pharmacy

☐ FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

☐ Cancel Request

P (844)-323-7399 | F (866)-588-0371 | info@cloudtophealth.com

SECTION 2 - AFREZZA QUESTIONNAIRE

PRESCRIBER INFORMATION			
First Name:	Last Name:	NPI:	
Address:	City:	State:	Zip:
HCP Contact:	Phone:	Fax	Email:

PATIENT INFORMATION			
First Name:	Last Name:	DOB:	
Address:	City:	State:	Zip:

CLINICAL INFORMATION

What is the patient's diagnosis?

☐ Type 1 Diabetes ☐ Type 2 Diabetes ☐ Other_____

Check ALL alternatives that the patient has experienced a treatment failure on (Attach Medication List):

☐ Novolog ☐ Humalog ☐ Novolin ☐ Humulin ☐ Admelog ☐ U200 ☐ U500
☐ Fiasp ☐ Lyumjev ☐ Aspart ☐ Lispro ☐ Apidra ☐ Two Orals Anti-diabetics
(specify in Note Section below)

Reasons for medication treatment failures that were checked above: (Check all below that apply)

- ☐ Patient not achieving A1C Goal
- ☐ Blood Glucose Variability (Lack of Time in Range)
- ☐ Intolerance to Therapy or Hypersensitivity
- ☐ Experienced Adverse Event including increased Hypoglycemia
- ☐ Contraindication
- ☐ Other (Please reference chart notes): _____

In the prescriber's opinion, alternatives will not be as effective for the patient due to: (Check all below that apply)

- ☐ Lipohypertrophy with malabsorption
- ☐ Gastroparesis
- ☐ High risk of Hypoglycemia
- ☐ Needle Phobia and unable to self-inject to the degree that patient presents with uncontrolled diabetes due to:
  ☐ Physical Disability ☐ Mental Disability ☐ Visual Impairment

Check ALL the following that apply:

- ☐ Contraindications to Afrezza have been ruled out
- ☐ FEV1 spirometry testing has been completed prior to initiation of therapy
- ☐ Type 1 diabetes patient will also receive basal insulin via injection or pump
- ☐ Diabetes controlled on Afrezza medication and with no adverse effects

Note Section:

All information is true and accurate to the best of my knowledge. Please sign below to validate.

Authorized Representative Signature:_____ **Title**: _____

Financial Assistance Attestation: If this prescription is not covered or has a high copayment, I request this patient be evaluated for financial assistance. I authorize the release of medical records and patient information for this purpose. I will not seek reimbursement for products provided through any free goods program. Please accept this as documentation as a reasonable attempt to obtain coverage for the prescribed product.