AFREZZA INFORMATION REQUEST FORM

REQUEST ID:

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

Hello,

The patient's insurance requires prior authorization for this prescription. If you would like ASPN Pharmacies to submit and follow up on your behalf, **please complete:**

- **Section 1 - Agency Authorization**
- **Section 2 - Afrezza Questionnaire**
- **Attach 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 **800-561-6174** or provide via our online portal, **aspnpharmacies.com**

Sincerely,
ASPN Pharmacies

SECTION 1 – AGENCY AUTHORIZATION

☐ **I authorize ASPN Pharmacies to complete and submit the prior authorization request on my behalf:** By checking this box and signing below, I authorize ASPN Pharmacies to act as my agent for purposes of completing and submitting all necessary prior authorization request paperwork and follow-up on such requests on my behalf, including any necessary appeals. In acting as my agent, ASPN Pharmacies and its pharmacists may sign prior authorization requests on my behalf. Any such signatures must be in the same of the person signing the prior authorization request and must expressly indicate that the person is signing the request on my behalf. I acknowledge and agree that neither ASPN Pharmacies or its data sources are liable to me as the prescriber or to the patient for the accuracy of completeness of any data provided in connection with this agency authority. I further certify that all information submitted to ASPN Pharmacies is true and accurate to the best of my knowledge.

☐ Electronic Prescription Has Been Sent to ASPN Pharmacies

☐ 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**: By checking this box and signing below, I am signifying that I do not authorize ASPN Pharmacies to complete and submit the prior authorization request on my behalf.

Prescriber Signature: _____ **Date**: _____

SECTION 2 - AFREZZA QUESTIONNAIRE

(Note: information provided below will be used to complete prior authorization request)

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 medications that the patient has tried and failed.
(Include any medications not listed in the "Medications Not Listed" checkbox):

☐ Novolog ☐ Humalog ☐ Novolin ☐ Humulin ☐ Admelog ☐ U200 ☐ U500
☐ Fiasp ☐ Lyumjev ☐ Aspart ☐ Lispro ☐ Apidra ☐ Two Orals Anti-diabetics (specify in Note Section below)
☐ Medications Not Listed:

_____

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.

Prescriber Signature: _____ **Date**:_____

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.