

Pharmacy Prior Authorization Form

Last Reviewed: Sept. 11

For Prior Authorization please fax to: 616 942-8206

 This form applies to: Commercial Plan Medicaid Plan Medicare Plan

Inhalation Solutions used with a nebulizer

 Urgent Non-urgent

Member Name:	Member #:
DOB:	Gender:
Provider Name:	Provider Phone:
Provider Office Address:	
Provider Office Contact Name:	Provider Fax:
Provider Signature:	Provider NPI:
Date:	Member's PCP:

Select a drug and strength:

Drug Name	Strength
<input type="checkbox"/> Isoetharine HCL	<input type="checkbox"/> 10MG/ML
<input type="checkbox"/> Tobi (Tobramycin /0.25 Normal Saline)	<input type="checkbox"/> 300MG/5ML
<input type="checkbox"/> Virazole (Ribavirin)	<input type="checkbox"/> 6G
<input type="checkbox"/> Accuneb/Proventil/Airet/ (Albuterol Sulfate)	<input type="checkbox"/> 0.21MG/ML <input type="checkbox"/> 0.42MG/ML <input type="checkbox"/> 5mg/ML <input type="checkbox"/> 0.83MG/ML
<input type="checkbox"/> Duoneb (Albuterol Sulfate/Ipratropium)	<input type="checkbox"/> 2.5-0.5/3
<input type="checkbox"/> Ipratropium Bromide	<input type="checkbox"/> 0.2MG/ML
<input type="checkbox"/> Sodium Chloride	<input type="checkbox"/> 0.9% <input type="checkbox"/> 10% <input type="checkbox"/> 3%,
<input type="checkbox"/> Pulmicort (Budesonide)	<input type="checkbox"/> 0.25MG/2ML <input type="checkbox"/> 0.5MG/2ML
<input type="checkbox"/> Survanta (Beractant)	<input type="checkbox"/> 25MG/ML
<input type="checkbox"/> Infasurf (Calfactant)	<input type="checkbox"/> 35MG/ML
<input type="checkbox"/> Curosurf (Poractant Alfa)	<input type="checkbox"/> 120MG/1.5 <input type="checkbox"/> 240MG/3ML
<input type="checkbox"/> Intal (Cromolyn Sodium)	<input type="checkbox"/> 20MG/2ML
<input type="checkbox"/> Pulmozyme (Dornase Alfa)	<input type="checkbox"/> 1MG/ML

Dose: _____ Start date: _____

Priority Health Precertification Requirements:

Authorization of inhalation solutions require:

- If being used with a nebulizer in the home, it is considered a Part B benefit
- If **not** being used with a nebulizer in the home, it is considered a Part D benefit

Please Complete the Following Information:

Diagnosis: _____

Medication is being used in a nebulizer:

- Yes
 No

Patient resides in a long term care facility:

- Yes
 No

Note: If none of the above is applicable to this member, please check which, if any, of the following apply:

- All covered Part D drugs on any tier of a plan's formulary would not be as effective for the enrollee as the non-formulary drug, and/or would have adverse effects
- The number of doses available under a dose restriction for the prescription drug:
 - Has been ineffective in the treatment of the enrollee's disease or medical condition or,
 - Based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance
- The prescription drug alternative(s) listed on the formulary or required to be used in accordance with step therapy requirements:
 - Has been ineffective in the treatment of the enrollee's disease or medical condition or, based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance; or
 - Has caused or, based on sound clinical evidence and medical and scientific evidence, is likely to cause an adverse reaction or other harm to the enrollee.
- None of the above apply

***** All fields must be complete and legible for Prior Authorization Review*****

Please fax this request to: (877)974-4411 toll free or (616)942-8206

YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX