

# Pharmacy Prior Authorization Form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to:  **Commercial (Traditional)**     **Commercial (Individual/Optimized)**

**Medicaid**

This request is:  **Urgent** (life threatening)     **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

## Pulmozyme<sup>®</sup> (dornase alfa)

### Member

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

ID #: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Requesting Provider: \_\_\_\_\_ Prov. Phone: \_\_\_\_\_ Prov. Fax: \_\_\_\_\_

Provider Address: \_\_\_\_\_

Provider NPI: \_\_\_\_\_ Contact Name: \_\_\_\_\_

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Product Information

New Request     Continuation Request

Drug product:  Pulmozyme 1 mg/mL solution

Start date (or date of next dose): \_\_\_\_\_

Date of last dose (if applicable): \_\_\_\_\_

Dosing frequency: \_\_\_\_\_

### Precertification Requirement

Before this drug is covered, the patient must meet all of the following requirements:

1. Must be used for cystic fibrosis

**Note:** Authorization for indications, dosing, or a route of administration not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

### Priority Health Precertification Documentation

#### A. What is the patient's diagnosis?

cystic fibrosis

Other: \_\_\_\_\_

Rationale for use: \_\_\_\_\_