PriorityHealth

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® (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

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 for a 12-month initial authorization:

1. Must be used for cystic fibrosis (CF)
2. Age ≥ 5 years
3. Prescribed by Pulmonologist or Infectious Disease specialist.

For continuation, the patient must meet all of the following requirements every 12-months:

1. Must provide FVC
2. Must provide documentation showing stable disease
3. Must provide documentation supporting decreased incidence of respiratory infections

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.

New Request
Priority Health Precertification Documentation

A. What is the patient's diagnosis?

☐ cystic fibrosis

☐ *Other:* _____

Rationale for use: _____

All fields must be complete and legible for review. Your office will receive a response via fax.

Updated 02/2018
Last Reviewed: 11/2019

B. What is the prescriber's specialty?

- ☐ Pulmonology
- ☐ Infectious Disease
- ☐ Other: _____

Continuation Request
Priority Health Precertification Documentation

A. What is the patient's FVC?

FVC: _____ **Date:** _____

B. Is there documentation showing stable disease?

- ☐ Yes
- ☐ No

C. Is there documentation showing a decreased incidence of respiratory infections?

- ☐ Yes
- ☐ No

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Updated 02/2018
Last Reviewed: 11/2019