PRIOR AUTHORIZATION REQUEST

BRINSUPRI

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1 Is the request for an INITIAL or a CONTINUATION of therapy with the requested medication?

[] Initial (If checked, go to 7)

[] Continuation (If checked, go to 2)

2 Is the patient currently receiving the requested medication? Yes No
[If no, skip to question 7.]

If you have any questions, call: 1-888-258-8250

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3	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 7.]	Yes	No
4	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 7.]	Yes	No
5	Has the patient been established on therapy for at least 3 months? [If no, skip to question 7.]	Yes	No
6	Has documentation been submitted to confirm that the patient has had a clinically significant response to therapy, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
7	What is the diagnosis or indication? [] Non-cystic fibrosis bronchiectasis (If checked, go to 8) [] Other (If checked, no further questions)		
8	Is the patient 12 years of age or older? [If no, no further questions.]	Yes	No
9	Has documentation been submitted to confirm chest computed tomography (CT) is positive for bronchiectasis within the past year? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
10	Does the patient meet one of the following? [] Patient is greater than or equal to 12 years of age and less than 18 years of age: Patient has had at least one pulmonary exacerbation in the last 12 months that resulted in the prescription of an antibiotic agent. ACTION REQUIRED: Submit supporting documentation. (If checked, go to 11) [] Patient is greater than or equal to 18 years of age: Patient has had at least two pulmonary exacerbations in the last 12 months that resulted in the prescription of an antibiotic agent. ACTION REQUIRED: Submit supporting documentation. (If checked, go to 11) [] Other (If checked, no further questions)		
11	Has cystic fibrosis been ruled out by one of the following: sweat chloride test is negative or mutation analysis of the cystic fibrosis transmembrane conductance regulator (CFTR) gene is negative? ACTION REQUIRED: Submit supporting	Yes	No

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	documentation. [If no, no further questions.]		
12	Does the provider attest that member does not have a primary diagnosis of chronic obstructive pulmonary disease (COPD) or asthma? [If no, no further questions.]	Yes	No
13	Does the provider attest that member is currently receiving at least 2 optimal supportive therapies for at least 3 months (examples include but are not limited to: airway clearance techniques, pulmonary rehabilitation, mucoactives, antibiotics)? [If no, no further questions.]	Yes	No
14	Does the provider attest that the patient is currently a non-smoker? [If no, no further questions.]	Yes	No
15	Is the requested medication prescribed by, or in consultation with, a pulmonologist? [If no, no further questions.]	Yes	No
16	Does the requested dose exceed Food and Drug Administration (FDA) approved label dosing for the requested indication? [Dosing: 10 mg or 25 mg once daily.]	Yes	No

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

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