



Send completed form to:
 Peach State Health Plan Pharmacy Department
 Fax: 1-866-374-1579

Pulmozyme

Prior Authorization Request

This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form toll-free to Peach State Health Plan at 1-866-374-1579.** If you have questions regarding the prior authorization, eligibility, drug copay or medication delivery; please contact Peach State Health Plan at 1-800-514-0083 option # 2.

Patient Name: _____ Date: _____
 Patient's ID: _____ Patient's Date of Birth: _____
 Physician's Name: _____ NPI#: _____
 Specialty: _____ Physician Office Telephone: _____ Physician Office Fax: _____
 Physician Office Address: _____

- Which drug is being prescribed?
 Pulmozyme, Dose: _____ Frequency: _____ Other _____
- What is the diagnosis? Cystic fibrosis (CF) Other _____
- Was the diagnosis confirmed by appropriate diagnostic or genetic testing? Yes No
- Will Pulmozyme be used in conjunction with standard therapies for Cystic fibrosis? Yes No
- How old is the patient? _____ years
- Is patient currently receiving Pulmozyme therapy? **If yes, Skip to # 8* Yes No
- Document patient's **PRE-TREATMENT** FEV₁: _____

Only answer the below questions if patient is currently on therapy

- Is the patient **less than 6** years of age? **If yes, Skip to # 11* Yes No
- Document patient's **CURRENT** FEV₁: _____
- Has the patient's lung function worsened while on Pulmozyme (defined as a decrease in FEV₁ by greater than 10%)? Yes No
- Is there a clinical reason to continue Pulmozyme therapy? Yes No
- If Yes, Document the clinical reason:** Patient had symptomatic improvement (e.g., decreased dyspnea, cough, fatigue; increased appetite, exercise tolerance; improved sleep) Patient had decreased number of pulmonary infections Patient had decreased number of pulmonary exacerbations Other _____

****NOTE: We can NOT make a decision without a copy of lab results - Thank You****

Information given on this form is accurate as of this date:

X _____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Centene Pulmozyme-MD FAX - Update 03/14/2011