



EXUBERA (inhaled human insulin)

Member Information

Relationship (Circle)

Name _____
Enrollment / Cardholder ID _____
Group / Plan _____
Birth Date _____
Address _____
City State Zip _____

Subscriber _____ Spouse _____ Dependent _____
Gender (Circle)
Male _____ Female _____
AGE: _____

Practitioner Information

Name _____
Agent / Contact Name _____
Specialty _____
Office / Clinic Name _____
Address _____
City State Zip _____
Phone () - _____
Fax () - _____
Email _____ @ _____

**Primary Diagnosis Condition /
Diagnosis Related – Reason for Request**

- **Type 1 diabetes** – Is the patient on a regimen that includes longer-acting insulin? **Y / N**
- **Type 2 diabetes** – Is this being used as
 - Monotherapy? **Y / N** if not,
 - In combination with oral agents? Please define: _____
 - In combination with longer-acting insulin? Please define: _____
- Please provide documented failure or contraindication to formulary injectable insulin therapies: _____
- Does the patient suffer of any underlying lung diseases? (such as asthma or COPD) **Y / N** If yes, please define: _____
- Does the patient smoke? **Y / N**
- Has the patient discontinued smoking less within the last 6 months? **Y / N**

Strength / Dose

Duration of Therapy (Expected)

**Formulary Alternatives
Attempted/Outcome**

Clinical Drug / Lab History Pertinent to Request

Contact Pharmacy? **Y** **N**

Pharmacy Phone Number

Practitioner Signature

Date Received: _____
Reviewed By: _____
Forwarded To: _____

**FAX Form to
877-800-5633**

HealthTrans Prior Authorization
866-805-1690