HEALTHY U CHIP

PRIOR AUTHORIZATION REQUEST FORM
YUPELRI®

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U CHIP Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Yupelri® (revefenacin)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
1. Is the member 18 years of age or older?	☐	☐	
2. Is the requesting provider a pulmonologist or in consultation with a pulmonologist?	☐	☐	
3. Has the member been diagnosed with moderate to severe COPD (i.e. COPD GOLD stage II, III, IV)?	☐	☐	**Please provide documentation**
4. Does documentation indicate the member is a non-smoker or smoking cessation has been addressed?	☐	☐	**Please provide documentation**
5. Does the member have a cognitive or physical impairment that limits their ability to use a metered dose inhaler (MDI) or dry powder inhaler (DPI)?	☐	☐	**Please provide documentation**
6. Is the member unable to generate adequate inspiratory force to use a dry powder inhaler (e.g. peak inspiratory flow rate (PIFR) <60L/min)?	☐	☐	**Please provide documentation**
7. Has the member tried at least 2 of the following preferred medications for at least 3 months with an inadequate response: • Ipratropium bromide solution for nebulizer • Incruse® Ellipta® (umedclidinium) • Spiriva® Handihaler® (tiotropium) • Spiriva® Respimat® (tiotropium)	☐	☐	**Please provide documentation**

8. Was the member unable to try two of the preferred medications listed in question 7 due to a medical reason?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Has the member's therapy been re-evaluated within the past 12 months?	☐	☐	
3. Has the member had a reduction in symptoms?	☐	☐	**Please provide documentation**
4. Has the member had a reduction symptoms and in the number and frequency of exacerbations?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician Signature:			

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Policy: PHARM-CHIP-087
Origination Date: 07/01/2024
Reviewed/Revised Date:
Next Review Date:
Current Effective Date: 07/01/2024