HEALTH PLANS
UNIVERSITY OF UTAH

PRIOR AUTHORIZATION REQUEST FORM
PULMOZYME®

For authorization, please answer each question and fax this form PLUS chart notes back to the U of U Health Plans Prior Authorization Department at 888-509-8142.

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: University of Utah Health Employees: 855-856-5690, Individual & Family Plans : 855-869-4769, Commercial Groups: 855-859-4892, MHC 855-885-7695

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 request: ☐ Pulmozyme® (dornase alfa)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Does the member have a confirmed laboratory diagnosis of cystic fibrosis?	☐	☐	
2. Is the prescriber a pulmonologist or a physician with expertise in caring for cystic fibrosis patients?	☐	☐	
3. Has the member had a trial and failure to hypertonic saline?	☐	☐	**Please provide documentation**
4. If requesting twice daily dose of Pulmozyme®, has the member trialed once daily dosing?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Has the member's therapy been re-evaluated within the past 6 months?	☐	☐	
3. Has the therapy shown to be effective with an improvement or stabilization in condition?	☐	☐	**Please provide documentation**
4. Does the member show a continued medical need for the therapy?	☐	☐	**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's Signature:

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

Policy: PHARM- 045
Origination Date: 04/01/2016
Reviewed/Revised Date: 05/18/2022
Next Review Date: 05/18/2023
Current Effective Date: 06/01/2022

Confidentiality Notice

This document and any accompanying document contain confidential information and is intended for the use of the individual or entity named on this transmission sheet. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or the taking of any action in reliance on the contents of this information is strictly prohibited and the document should be returned to this office immediately. If you have received this facsimile in error, please notify us by telephone immediately and destroy document received.