MOLINA HEALTHCARE

Iowa Health Link Iowa HHS Hawki Iowa HHS

Request for Prior Authorization
Ensifentrine (Ohtuvayre)

(PLEASE PRINT – ACCURACY IS IMPORTANT)

FAX Completed Form To
1 (877) 733-3195

Provider Help Desk
1 (844) 236-1464

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

Prior authorization (PA) is required for ensifentrine (Ohtuvayre). Requests for non-preferred agents may be considered when documented evidence is provided that the use of the preferred agent(s) would be medically contraindicated. Payment will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following conditions are met:

1. **Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and**
2. **Patient has a diagnosis of moderate to severe COPD when all of the following are met:**
    a. **FEV1/FVC ratio < 0.7; and**
    b. **Post-bronchodilator FEV1 % predicted of 30% to 79%; and**
    c. **Modified Medical Research Council (mMRC) dyspnea score of ≥ 2 or a COPD Assessment Test (CAT) score ≥ 10; and**
3. **Patient is adherent with COPD treatments, meeting one of the following criteria:**
    a. **The patient has a blood eosinophil of ≥ 100 and has experienced an exacerbation while adherent to a current 60-day trial of a triple combination regimen consisting of a long-acting beta agonist (LABA), a long-acting muscarinic antagonist (LAMA), and an inhaled corticosteroid (ICS); or**
    b. **The patient has a blood eosinophil of < 100 and has experienced an exacerbation while adherent to a current 60-day trial of a dual combination regimen consisting of a LABA and LAMA; and**
4. **Dual or triple combination regimen will be continued in combination with ensifentrine (Ohtuvayre).**

The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

If the criteria for coverage are met, initial authorization will be given for 6 months to assess the response to treatment. Additional authorizations will be considered upon documentation of a response to treatment (e.g. improved dyspnea, decrease exacerbations) and patient continues their dual or triple combination regimen.

Non-Preferred

☐ Ohtuvayre

Strength	**Usage Instructions**	**Quantity**	**Day's Supply**
_____	_____	_____	_____

Diagnosis:_____

Provide all of the following information for a diagnosis of moderate to severe COPD:

a. FEV1/FVC ratio: _____ Date obtained: _____

b. Post-bronchodilator FEV1 % predicted:_____ Date obtained: _____

Request for Prior Authorization
Ensifentrine (Ohtuvayre)
(PLEASE PRINT – ACCURACY IS IMPORTANT)

c. mMRC dvsonea score: _____ OR **CAT score:** _____ Date obtained: _____

Blood eosinophil count: _____ Date obtained: _____

Patient has a blood eosinophil of ≥ 100 and has experienced exacerbation while adherent to a current 60 day trial of a triple combination regimen:

LABA Trial:

Name/dose:_____Trial dates:_____

Failure reason/medical contraindication: _____

LAMA Trial:

Name/dose:_____Trial dates:_____

Failure reason/medical contraindication: _____

ICS Trial:

Name/dose:_____Trial dates:_____

Failure reason/medical contraindication: _____

_____

Patient has a blood eosinophil of < 100 and has experienced exacerbation while adherent to a current 60 day trial of a triple combination regimen:

LABA Trial:

Name/dose:_____Trial dates:_____

Failure reason/medical contraindication: _____

LAMA Trial:

Name/dose:_____Trial dates:_____

Failure reason/medical contraindication: _____

Renewal:

Document response to treatment:. _____

_____

Is patient currently on dual or triple combination regimen? ☐ Yes ☐ No
Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission

IMPORTANT NOTE: *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Health and Human Services, that the member continues to be eligible for Medicaid.*