

Request for Prior Authorization
Brensocatib (Brinsupri)
(PLEASE PRINT – ACCURACY IS IMPORTANT)

Date: _____ Treatment: _____

Patients 12 to 17 years of age: Document history of ≥ 1 pulmonary exacerbation requiring antibiotic treatment in the past 12 months:

Date: _____ Treatment: _____

Patient has experienced at least 2 of the following symptoms in the previous 12 months:

- Cough
- Chronic sputum production
- Chronic respiratory infections

Has patient been counseled on the importance of abstinence from tobacco and, if a current smoker, been encouraged to enroll in a smoking cessation program?

- Yes
- No

Is prescriber a pulmonologist or infectious disease specialist?

Yes, document specialty: _____

No (If no, note consultation with specialist):

Consultation Date: _____ Physician Name, Specialty & Phone: _____

Renewal Requests

Document positive clinical response to therapy:

- Improvement in or stabilization of symptoms
- Reduction in or stabilization of the frequency, severity, or duration of exacerbations
- Reduction in the decline of FEV₁

Attach lab results and other documentation as necessary.

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