MOLINA HEALTHCARE

Iowa Department of Human Services

Iowa Health Link IOWA HHS Hawki Iowa HHS

Request for Prior Authorization
MANNITOL INHALATION POWDER (BRONCHITOL)

(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 is required for mannitol inhalation powder (Bronchitol). Payment will be considered when the following criteria are met:

1. **Patient has a diagnosis of cystic fibrosis; and**
2. **Patient meets the FDA approved age; and**
3. **Prescriber is a cystic fibrosis specialist or pulmonologist; and**
4. **Documentation is provided that patient has successfully completed the Bronchitol tolerance test (BTT); and**
5. **Patient will pre-medicate with a short-acting bronchodilator; and**
6. **Dose does not exceed the FDA approved dose.**

If the criteria for coverage are met, an initial authorization will be given for 6 months. Additional approvals will be granted if the following criteria are met:

1. **Adherence to mannitol inhalation powder (Bronchitol) therapy is confirmed; and**
2. **Patient has demonstrated improvement or stability of disease symptoms, such as improvement in FEV_1, decrease in pulmonary exacerbations, decrease in hospitalizations, or improved quality of life.**

☐ **Bronchitol**

Strength	Dosage Instructions	Quantity	Days Supply
_____	_____	_____	_____

Diagnosis: _____

Prescriber Specialty: ❑ CF Specialist ❑ Pulmonologist ❑ Other (specify): _____

Has patient successfully completed the BTT? ☐ Yes Date: _____ ☐ No

Will patient pre-medicate with a short-acting bronchodilator? ☐ Yes Drug Name: _____ ☐ No

Renewal Requests:

Patient is adherent to Bronchitol therapy: ☐ Yes ☐ No

Document positive response to therapy: _____

_____

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 Human Services, that the member continues to be eligible for Medicaid.*