IOWA Health and Human Services

Request for Prior Authorization
Brensocatib (Brinsupri)

FAX Completed Form To
1 (800) 574-2515
Provider Help Desk
1 (877) 776-1567

(PLEASE PRINT – ACCURACY IS IMPORTANT)

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 brensocatib (Brinsupri). Payment will be considered for an FDA approved or compendia indicated diagnosis 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 non-cystic fibrosis bronchiectasis (NCFB) confirmed by a chest CT scan; and

3. Patient is 18 years of age or older with a history of ≥ 2 pulmonary exacerbations requiring antibiotic treatment in the previous 12 months; or

4. Patient is 12 to 17 years of age with ≥ 1 pulmonary exacerbation requiring antibiotic treatment in the previous 12 months; and

5. Patient has experienced at least 2 of the following symptoms in the previous 12 months: cough, chronic sputum production, and/or chronic respiratory infections; and

6. Patient has been counseled on the importance of abstinence from tobacco and, if a current smoker, been encouraged to enroll in a smoking cessation program; and

7. Is prescribed by or in consultation with a pulmonologist or infectious disease specialist.

Initial requests will be approved for 12 months. Additional authorizations will be considered annually with documentation of a positive clinical response to therapy, demonstrated by at least one of the following:

1. **Improvement in or stabilization of symptoms; or**
2. **Reduction in or stabilization of the frequency, severity, or duration of exacerbations; or**
3. **Reduction in the decline of FEV_1.**

Preferred

☐ Brinsupri

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

Diagnosis (attach chest CT scan): _____

Patients 18 years of age or older: Document history of ≥ 2 pulmonary exacerbations requiring antibiotic treatment in the past 12 months:

Date: _____ Treatment: _____

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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 FEV_1

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.*