UnitedHealthcare Community Plan

ADVAIR / DULERA / SYMBICORT / BREO ELLIPTA

PRIOR AUTHORIZATION REQUEST FORM

Complete ENTIRE form and Fax to: 866-940-7328

SECTION A - PATIENT INFORMATION		
Today's Date:	First Name:	Last Name:
Member ID #:	Address:	
City:	State:	Zip:
Phone:	DOB:	Allergies:
Primary Insurance:	Policy #:	Group #:

Is the requested medication NEW □ or a CONTINUATION of THERAPY□? If so, start date:_____

Is this patient currently hospitalized? □Yes □No

Is the patient residing in a LTC facility? □Yes □No

SECTION B - PHYSICIAN INFORMATION				
First Name:		Last Name:		M.D./D.O.
Address:		City:	State:	Zip:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax Attention to:				

Medication to be Administered: □Physician's Office □Patient's Home □LTC Facility □Other

SECTION C - MEDICAL INFORMATION	
Medication:	**Strength:**
Directions for use:	
Diagnosis (Please be specific & provide as much information as possible)**:**	**ICD 10 Code:**

For what indication is the medication being prescribed? (Check response)

☐ Asthma ☐ COPD (Chronic Obstructive Pulmonary Disease) ☐ Other (specify): _____

Is this patient's asthma diagnosis confirmed as severe persistent asthma? (Check response) ☐ YES ☐ NO

If yes, please provide date of diagnosis: _____

Has this patient tried any of the following medications?

Inhaled Corticosteroid (e.g. Flovent, Asmanex, Pulmicort, Azmacort, or QVar) (Check response) ☐ YES* ☐ NO

Inhaled Anticholinergic (e.g. Spiriva, Atrovent, or Combivent) (Check response) ☐ YES* ☐ NO

Inhaled Long-Acting Beta 2-Agonist (e.g. Serevent or Foradil) (Check response) ☐ YES* ☐ NO

*For any medications marked YES above please provide the following:

Name of Medication:	Dates of Therapy:	Reason for Discontinuing Therapy:

**Please provide all information requested on this form. Incomplete forms may not be reviewed for medical necessity. **

Physician Signature: _____ **Date:** _____

Phone: 800-310-6826 Fax: 866-940-7328 Website: www.uhccommunityplan.com