

ADVAIR / DULERA / SYMBICORT

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

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:	Strength:
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Directions for use:

Diagnosis (Please be specific & provide as much information as possible):	ICD 10 Code:
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For Asthma:

Did the patient exhibit an inadequate response to treatment with at least a 30 day trial of an inhaled corticosteroid? (e.g. Flovent, Asmanex, Pulmicort, Azmacort, or Qvar) Yes ___ No ___ If yes, provide name of medication and dates of therapy: _____

Did the patient experience an intolerance/adverse reaction to previous therapy or has a documented contraindication to treatment with an inhaled corticosteroid? (e.g. Flovent, Asmanex, Pulmicort, Azmacort, or Qvar) Yes ___ No ___ If yes, provide details: _____

Is this patient's asthma diagnosis confirmed as severe persistent asthma? Yes ___ No ___ If yes, provide date of diagnosis: _____

For COPD (Emphysema, Chronic Bronchitis):

Has the patient exhibited an inadequate response to treatment with at least a 60 day trial of EITHER a long-acting beta2-agonist (e.g. Foradil, Serevent) OR an orally inhaled anticholinergic agent (e.g. Spiriva, Atrovent, Combivent)? Yes ___ No ___ If yes, provide name of medication and dates of therapy: _____

Has the patient exhibited an intolerance/adverse reaction to previous therapy with at least a two-month trial of a long-acting beta2-agonist (e.g. Foradil, Serevent) OR an orally inhaled anticholinergic agent (e.g. Spiriva, Atrovent, Combivent)? Yes ___ No ___ If yes, provide details: _____

Physician Signature: _____ **Date:** _____

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