UnitedHealthcare Community Plan

# 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:**

**Directions for use:**

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

## 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 *BOTH* a long-acting beta2-agonist (e.g. Foradil, Serevent) *AND* 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 both a long-acting beta2-agonist (e.g. Foradil, Serevent) *AND* an orally inhaled anticholinergic agent (e.g. Spiriva, Atrovent, Combivent)? Yes____ No____ If yes, provide details:

______________________________

**Physician Signature:** ______________________________ **Date:** ______________

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