

# 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:

<b>Medication:</b>	<b>Strength:</b>
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**Directions for use:**

<b>Diagnosis</b> (Please be specific & provide as much information as possible):	<b>ICD-10 Code:</b>
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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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