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:** _____