UnitedHealthcare Community Plan

Inhaled Corticosteroid
Long Acting Beta Agonist Combinations
PRIOR AUTHORIZATION REQUEST FORM

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**
This form contains multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance:	Policy #:	Group #:

Is the requested medication □ New or □ Continuation of Therapy? If continuation, list start date: ________________
Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: ________________

Section B - Physician Information

First Name:		Last Name: M.D./D.O.		
Address:		City:	State:	ZIP code:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax attention to:				

Section C - Medical Information

Medication:	**Strength:**
Directions for use:	**Quantity:**
Diagnosis (Please be specific & provide as much information as possible)**:**	**ICD-10 CODE:**

Is this member pregnant? □ Yes □ No If yes, what is this member's due date? _______________

Section D – Previous Medication Trials

Medications	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs
Please refer to www.uhccommunityplan.com for a list of preferred alternatives

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Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

All Requests:

- What is the patient's diagnosis? (Check all that apply)
□ Asthma (not severe) □ Severe Persistant Asthma □ COPD □ Other, list diagnosis: ________________________

- Does the patient have a history of failure, contraindication, or intolerance to treatment with generic Fluticasone/Salmeterol and/or Breo Ellipta? □ Yes □ No
(If yes, complete Section D above with medication information, including dose, duration, and date of trial)

Requests for Fluticasone-Salmeterol (AirDuo) & Breo Ellipta:

- Does the patient have a history of failure, contraindication, or intolerance to one treatment with at least a 30 day trial of an inhaled corticosteroid (e.g., Arnuity Ellipta, Flovent, Qvar, Asmanex, Pulmicort)? □ Yes □ No
(If yes, complete Section D above with medication information, including dose, duration, and date of trial)

- Does the patient have a history of failure, contraindication, or intolerance to treatment with at least a two month trial of one of the following: □ Yes □ No (check which applies)
(If yes, complete Section D above with medication information, including dose, duration, and date of trial)
□ A long-acting beta-agonist (e.g., Foradil, Serevent, Striverdi, Arcapta)
□ An orally inhaled anticholinergic agent (e.g., Spiriva, Atrovent, Combivent, Tudorza, Incruse Ellipta)
□ An orally inhaled anticholinergic agent/ long-acting beta-agonist combination agent (e.g., Anoro Ellipta, Stiolto Respimat)

Physician Signature: ____ Date: ____________________

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Website: uhccommunityplan.com