EXPRESS SCRIPTS®

Prior Authorization Form

Combination Beta2-Agonist/Corticosteroid Inhalers

This form is based on Express Scripts standard criteria and may not be applicable to all patients; certain plans and situations may require additional information beyond what is specifically requested.

Additional forms available: www.express-scripts.com/pa

Fax completed form to **1-877-329-3760**

If this an **URGENT** request, please call 1-800-753-2851

Patient Information

Patient First Name: _____

Patient Last Name: _____

Patient ID#: _____

Patient DOB: _____

Patient Phone #: _____

Prescriber Information

Prescriber Name: _____

Prescriber DEA/NPI **(required)**: _____

Prescriber Phone #: _____

Prescriber Fax #: _____

Prescriber Address: _____

State: _____ Zip Code: _____

Primary Diagnosis: _____ ICD Code: _____

Please indicate which drug and strength is being requested:

- ☐ Advair Diskus 100mcg-50mcg/actuation Powder for Inhalation
- ☐ Advair Diskus 250mcg-50mcg/actuation Powder for Inhalation
- ☐ Advair Diskus 500mcg-50mcg/actuation Powder for Inhalation
- ☐ Advair HFA 45mcg-21mcg/actuation Inhalation Aerosol
- ☐ Advair HFA 115mcg-21mcg/actuation Inhalation Aerosol
- ☐ Advair HFA 230mcg-21mcg/actuation Inhalation Aerosol
- ☐ Dulera 100mcg/5mcg/actuation Inhalation Aerosol
- ☐ Dulera 200mcg/5mcg/actuation Inhalation Aerosol
- ☐ Symbicort 160mcg-4.5mcg/actuation Inhalation Aerosol
- ☐ Symbicort 80mcg-4.5mcg/actuation Inhalation Aerosol

Directions for use (i.e. QD, BID, PRN & Qty): _____

Please complete the clinical assessment:

1. What is the indication or diagnosis?
   - ☐ Asthma or RAD (reactive airway disease)
   - ☐ Acute Bronchitis
   - ☐ Chronic Bronchitis
   - ☐ Emphysema
   - ☐ Postinfectious cough (cough persisting after an acute respiratory infection has resolved)
   - ☐ COPD (chronic obstructive pulmonary disease)
   - ☐ All other indications or diagnoses: _____

     _____

2. Does the patient have coordination issues or arthritis which makes use of a metered-dose inhaler difficult?
   - ☐ Yes
   - ☐ No

3. Has the patient tried Symbicort or Dulera?
   - ☐ Yes
   - ☐ No

Are there any other comments, diagnoses, symptoms, and/or any other information the physician feels is important to this review?

_____

_____

_____

_____

_____

_____

_____

Prescriber Signature: _____Date: _____

Office Contact Name: _____ Phone Number: _____

Based upon each patient's prescription plan, additional questions may be required to complete the prior authorization process. If you have any questions about the process or required information, please contact our prior authorization team at the number listed on the top of this form.

Prior Authorization of Benefits is not the practice of medicine or a substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for the patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions.