



PRIOR AUTHORIZATION REQUEST

Asthma and COPD - NF

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number:	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength:	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests.

- | | | | |
|---|--|-----|----|
| 1 | Is this request for INITIAL therapy or for CONTINUATION of therapy?
<input type="checkbox"/> Initial (If checked, go to 7)

<input type="checkbox"/> Continuation (If checked, go to 2) | | |
| 2 | Is the patient currently receiving the requested medication?
[If no, skip to question 7.] | Yes | No |
| 3 | Has the patient been receiving medication samples for the requested medication?
[If yes, skip to question 7.] | Yes | No |

If you have any
questions, call:
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4	<p>Does the patient have a previously approved prior authorization (PA) on file with the current plan?</p> <p>[NOTE: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.]</p> <p>[If no, skip to question 7.]</p>	Yes	No
5	<p>Has the patient been established on therapy for at least 3 months?</p> <p>[If no, skip to question 7.]</p>	Yes	No
6	<p>Has the patient shown improvement in asthma control or chronic obstructive pulmonary disease (COPD) symptoms (e.g., reduced exacerbations, improved FEV1, reduced rescue inhaler use)?</p> <p>[No further questions.]</p>	Yes	No
7	<p>What is the diagnosis or indication?</p> <p><input type="checkbox"/> Asthma (If checked, go to 8)</p> <p><input type="checkbox"/> Chronic Obstructive Pulmonary Disease (COPD) (If checked, go to 21)</p> <p><input type="checkbox"/> Other (If checked, no further questions)</p>		
8	<p>Does the patient have a documented diagnosis for asthma? ACTION REQUIRED: Submit supporting documentation.</p> <p>[If no, no further questions.]</p>	Yes	No
9	<p>Is the requested medication appropriate based on the patient's age and indication?</p> <p>[If no, no further questions.]</p>	Yes	No
10	<p>What medication is being requested?</p> <p><input type="checkbox"/> Short-acting beta-agonist (SABA): ProAir, Ventolin HFA, Xopenex (If checked, go to 11)</p> <p><input type="checkbox"/> Long-acting beta-agonists (LABA): Serevent Diskus (If checked, go to 12)</p> <p><input type="checkbox"/> Combination of inhaled corticosteroids (ICS) and short-acting beta-agonist (SABA): Airsupra (If checked, go to 13)</p> <p><input type="checkbox"/> Inhaled corticosteroids (ICS): Flovent, Alvesco, Asmanex Twisthaler, Asmanex HFA, Pulmicort Flexhaler, etc. (If checked, go to 14)</p> <p><input type="checkbox"/> Combination of inhaled corticosteroids (ICS) and long-acting beta-agonists (LABA): Advair Diskus, Advair HFA, Dulera, Breo, etc (If checked, go to 17)</p> <p><input type="checkbox"/> Long-acting muscarinic antagonist (LAMA): Spiriva Respimat (If checked, go to 20)</p>		

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☐ Other (If checked, no further questions)

- | | | | |
|----|--|-----|----|
| 11 | Did the patient experience an intolerance, adverse side effects, or treatment failure to the generic formulation of albuterol HFA made by TWO different manufacturers?
[No further questions.] | Yes | No |
| 12 | Is the patient currently using an inhaled corticosteroid or will be using an inhaled corticosteroid in combination with the requested medication?
[No further questions.] | Yes | No |
| 13 | Has the patient tried and failed or had an inadequate response to a maximum tolerated dose of ALL of the following formulary combination inhaled corticosteroid (ICS) and long-acting beta-agonist (LABA) agents: A) Fluticasone-salmeterol (generic formulation of AirDuo), B) Breyna or budesonide-formoterol (generic formulations of Symbicort), C) Wixela or fluticasone-salmeterol (generic formulations of Advair Diskus)?
[No further questions.] | Yes | No |
| 14 | What inhaled corticosteroid (ICS) product is being requested?
<input type="checkbox"/> Flovent (If checked, go to 15)

<input type="checkbox"/> Alvesco (If checked, go to 16)

<input type="checkbox"/> Asmanex Twisthaler or Asmanex HFA (If checked, go to 16)

<input type="checkbox"/> Pulmicort Flexhaler (If checked, go to 16)

<input type="checkbox"/> Other (If checked, go to 16) | | |
| 15 | Did the patient experience a documented intolerance, adverse side effects, or treatment failure to the generic formulation of fluticasone propionate made by TWO different manufacturers? ACTION REQUIRED: Submit supporting documentation.
[No further questions] | Yes | No |
| 16 | Has the patient tried and failed or had a contraindication to ALL of the following formulary inhaled corticosteroid (ICS) agents: A) Fluticasone propionate HFA, B) Arnuity Ellipta, C) Qvar, D) Budesonide inhalation suspension?
[No further questions.] | Yes | No |
| 17 | What combination of inhaled corticosteroids (ICS) and long-acting beta-agonists (LABA) medication is being requested?
<input type="checkbox"/> Symbicort (If checked, go to 18)

<input type="checkbox"/> Advair Diskus, Advair HFA, or non-formulary generic formulation (If checked, go to 18) | | |

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☐ Dulera (If checked, go to 19)

☐ Breo, fluticasone furoate-vilanterol (If checked, go to 19)

☐ Other (If checked, go to 19)

- | | | | |
|----|---|-----|----|
| 18 | Did the patient experience an intolerance, adverse side effects, or treatment failure to the generic formulations of the requested medication made by TWO different manufacturers currently on formulary?
[No further questions.] | Yes | No |
| 19 | Has the patient tried and failed or had an inadequate response to a maximum tolerated dose of ALL the following generic formulary combination inhaled corticosteroid (ICS) and long-acting beta-agonists (LABA) agents: A) Fluticasone-salmeterol (generic formulation of AirDuo), B) Breyna or budesonide-formoterol (generic formulations of Symbicort), C) Wixela or fluticasone-salmeterol (generic formulations of Advair Diskus)?
[No further questions.] | Yes | No |
| 20 | Has the patient tried and failed or had a contraindication to Atrovent HFA?
[No further questions.] | Yes | No |
| 21 | Does the patient have a documented diagnosis of moderate to severe chronic obstructive pulmonary disease (COPD), including chronic bronchitis and/or emphysema? ACTION REQUIRED: Submit supporting documentation.
[If no, no further questions.] | Yes | No |
| 22 | Is the patient 18 years of age or older?
[If no, no further questions.] | Yes | No |
| 23 | What medication is being requested?
<input type="checkbox"/> Long-acting beta-agonist (LABA): Serevent Diskus (If checked, go to 24)

<input type="checkbox"/> Long-acting muscarinic antagonist (LAMA): Spiriva Respimat, Spiriva Handihaler, tiotropium bromide, Tudorza, or Yulperi (If checked, go to 26)

<input type="checkbox"/> Combination of inhaled corticosteroid (ICS) and long-acting beta-agonist (LABA): Breo Ellipta, Advair Diskus, Advair HFA, non-formulary fluticasone-salmeterol formulations, Symbicort, etc. (If checked, go to 31)

<input type="checkbox"/> Triple Therapy: Breztri Aero (If checked, go to 34)

<input type="checkbox"/> Other (If checked, no further questions) | | |
| 24 | Has the patient tried and failed or had an inadequate response to the following long-acting beta-agonist (LABA): Striverdi Respimat?
[If no, no further questions.] | Yes | No |

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25	<p>Has the patient tried and failed or had an inadequate response to a maximum tolerated dose of ALL the following preferred long-acting beta-agonist (LABA)/long-acting muscarinic antagonist (LAMA) combination medications: A) Anoro Ellipta, B) Bevespi Aerosphere, C) Stiolto Respimat? [No further questions.]</p>	Yes	No
26	<p>Has the patient tried and failed or had an inadequate response to the following long-acting muscarinic antagonist (LAMA): Incruse Ellipta? [If no, no further questions.]</p>	Yes	No
27	<p>Has the patient tried and failed or had an inadequate response to a maximum tolerated dose of ALL of the following preferred long-acting beta-agonist (LABA)/long-acting muscarinic antagonist (LAMA) combination medications: A) Anoro Ellipta, B) Bevespi Aerosphere, C) Stiolto Respimat? [If no, no further questions.]</p>	Yes	No
28	<p>Does the patient have a history of asthma or other respiratory disorders besides chronic obstructive pulmonary disease (COPD)? [If yes, no further questions.]</p>	Yes	No
29	<p>Does the patient have a recent history of myocardial infarction, unstable or life-threatening cardiac arrhythmia, or hospitalization for heart failure within the past year? [If yes, no further questions.]</p>	Yes	No
30	<p>Does the patient have moderate to severe renal impairment (creatinine clearance less than or equal to 50 mL/min)? [No further questions.]</p>	Yes	No
31	<p>What combination inhaled corticosteroid (ICS) and long-acting beta-agonist (LABA) medication is being requested? <input type="checkbox"/> Advair Diskus, Advair HFA, or non-formulary generic formulations (If checked, go to 32) <input type="checkbox"/> Symbicort (If checked, go to 32) <input type="checkbox"/> Breo, fluticasone furoate-vilanterol trifenatate (If checked, go to 33) <input type="checkbox"/> Other (If checked, go to 33)</p>		
32	<p>Did the patient experience an intolerance, adverse side effects, or treatment failure to the generic formulations of the requested medication made by TWO different manufacturers? [No further questions.]</p>	Yes	No
33	<p>Has the patient tried and failed or had an inadequate response to a maximum tolerated dose of ALL of the following preferred combination inhaled corticosteroid</p>	Yes	No

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(ICS) and long-acting beta-agonist (LABA) agents: A) Breyna or budesonide-formoterol (generic formulations of Symbicort), B) Wixela or fluticasone-salmeterol (generic formulations of Advair Diskus)? ACTION REQUIRED: Submit supporting documentation.

[No further questions.]

- | | | | |
|----|--|-----|----|
| 34 | Does the patient have a history of at least one moderate or severe chronic obstructive pulmonary disease (COPD) exacerbation in the previous year?
[If no, no further questions.] | Yes | No |
| 35 | Does the patient have a history of other respiratory disorders besides chronic obstructive pulmonary disease (COPD) or asthma?
[If yes, no further questions.] | Yes | No |
| 36 | Does the patient have an unstable cardiovascular disease?
[If yes, no further questions.] | Yes | No |
| 37 | Does the patient have a clinically significant prostate hypertrophy or bladder neck obstruction?
[If yes, no further questions.] | Yes | No |
| 38 | Has the patient tried and failed or had an inadequate response to a maximum tolerated dose of TWO of the following preferred combination inhaled corticosteroid (ICS) and long-acting beta-agonist (LABA) agents: A) Breyna or budesonide-formoterol (generic formulations of Symbicort), B) Wixela or fluticasone-salmeterol (generic formulations of Advair Diskus)? ACTION REQUIRED: Submit supporting documentation.
[If no, no further questions.] | Yes | No |
| 39 | Has the patient tried and failed or had an intolerance to Trelegy Ellipta? | Yes | No |

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B: Physician Signature

PHYSICIAN SIGNATURE

DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior

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authorization as per Plan policy and procedures.

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