maryland physicians care
Medicaid with a Heart

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. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1	Is this request for INITIAL therapy or for CONTINUATION of therapy? [] Initial (If checked, go to 7) [] 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?	Yes	No

If you have any questions, call: 1-888-258-8250

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	[If yes, skip to question 7.]		
4	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [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.] [If no, skip to question 7.]	Yes	No
5	Has the patient been established on therapy for at least 3 months? [If no, skip to question 7.]	Yes	No
6	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)? [No further questions.]	Yes	No
7	What is the diagnosis or indication? [] Asthma (If checked, go to 8) [] Chronic Obstructive Pulmonary Disease (COPD) (If checked, go to 21) [] Other (If checked, no further questions)		
8	Does the patient have a documented diagnosis for asthma? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
9	Is the requested medication appropriate based on the patient's age and indication? [If no, no further questions.]	Yes	No
10	What medication is being requested? [] Short-acting beta-agonist (SABA): ProAir, Ventolin HFA, Xopenex (If checked, go to 11) [] Long-acting beta-agonists (LABA): Serevent Diskus (If checked, go to 12) [] Combination of inhaled corticosteroids (ICS) and short-acting beta-agonist (SABA): Airsupra (If checked, go to 13) [] Inhaled corticosteroids (ICS): Flovent, Alvesco, Asmanex Twisthaler, Asmanex HFA, Pulmicort Flexhaler, etc. (If checked, go to 14) [] Combination of inhaled corticosteroids (ICS) and long-acting beta-agonists (LABA): Advair Diskus, Advair HFA, Dulera, Breo, etc (If checked, go to 17) [] Long-acting muscarinic antagonist (LAMA): Spiriva Respimat (If checked, go to		

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	20) [] 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? [] Flovent (If checked, go to 15) [] Alvesco (If checked, go to 16) [] Asmanex Twisthaler or Asmanex HFA (If checked, go to 16) [] Pulmicort Flexhaler (If checked, go to 16) [] 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? [] Symbicort (If checked, go to 18) [] Advair Diskus, Advair HFA, or non-formulary generic formulation (If checked, go		

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	to 18) [] 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? [] Long-acting beta-agonist (LABA): Serevent Diskus (If checked, go to 24) [] Long-acting muscarinic antagonist (LAMA): Spiriva Respimat, Spiriva Handihaler, tiotropium bromide, Tudorza, or Yulperi (If checked, go to 26) [] 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) [] Triple Therapy: Breztri Aero (If checked, go to 34) [] 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?	Yes	No

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	[If no, no further questions.]		
25	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.]	Yes	No
26	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.]	Yes	No
27	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.]	Yes	No
28	Dose the patient have a history of asthma or other respiratory disorders besides chronic obstructive pulmonary disease (COPD)? [If yes, no further questions.]	Yes	No
29	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.]	Yes	No
30	Does the patient have moderate to severe renal impairment (creatinine clearance less than or equal to 50 mL/min)? [No further questions.]	Yes	No
31	What combination inhaled corticosteroid (ICS) and long-acting beta-agonist (LABA) medication is being requested? [] Advair Diskus, Advair HFA, or non-formulary generic formulations (If checked, go to 32) [] Symbicort (If checked, go to 32) [] Breo, fluticasone furoate-vilanterol trifenatate (If checked, go to 33) [] Other (If checked, go to 33)		
32	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.]	Yes	No
33	Has the patient tried and failed or had an inadequate response to a maximum	Yes	No

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	tolerated dose of ALL 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. [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	Dose 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

If you have any questions, call: 1-888-258-8250

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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 authorization as per Plan policy and procedures.

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