PRIOR AUTHORIZATION REQUEST

ASTHMA/COPD INHALERS

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? Yes No
[If no, skip to question 7.]

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

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3	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 7.]	Yes	No
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 of 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		

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	(LABA): Advair Diskus, Advair HFA, Dulera, Breo Ellipta, etc. (If checked, go to 17) [] Long-acting muscarinic antagonist (LAMA): Spiriva Respimat (If checked, go to 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

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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 to 18) [] Dulera (If checked, go to 19) [] Breo Ellipta, 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, Brovana (If checked, go to 24) [] Long-acting muscarinic antagonist (LAMA): Spiriva Respimat, Spiriva Handihaler, tiotropium bromide, Tudorza, or Yupelri (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-		

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	salmeterol formulations, Symbicort, etc. (If checked, go to 29) [] Triple Therapy: Breztri Aero (If checked, go to 32) [] Phosphodiesterase (PDE) 3/PDE4: Ohtuvayre inhalation suspension (If checked, go to 38) [] 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
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	Does the patient have moderate to severe renal impairment (creatinine clearance less than or equal to 50 mL/min)? [No further questions.]	Yes	No
29	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 30) [] Symbicort (If checked, go to 30) [] Breo Ellipta, fluticasone furoate-vilanterol trifenatate (If checked, go to 31) [] Other (If checked, go to 31)		
30	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?	Yes	No

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	[No further questions.]		
31	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 (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.]	Yes	No
32	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
33	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
34	Does the patient have an unstable cardiovascular disease? [If yes, no further questions.]	Yes	No
35	Does the patient have a clinically significant prostate hypertrophy or bladder neck obstruction? [If yes, no further questions.]	Yes	No
36	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
37	Has the patient tried and failed or had an intolerance to Trelegy Ellipta? [No further questions.]	Yes	No
38	Does the patient have moderate-to-severe airflow obstruction (post-bronchodilator FEV1 30 to 70% predicted normal)? [If no, no further questions.]	Yes	No
39	Does the patient have a Modified Medical Research Council (mMRC) dyspnea scale score greater than or equal to 2 or a COPD Assessment Test (CAT) score greater than or equal to 10? [If no, no further questions.]	Yes	No
40	Will the requested medication be used in combination with Roflumilast? [If yes, no further questions.]	Yes	No

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41	Does the patient have a diagnosis of other respiratory disorders (i.e., asthma, active tuberculosis, lung cancer, sarcoidosis, lung fibrosis, interstitial lung diseases, unstable sleep apnea, alpha-1 antitrypsin deficiency, pulmonary hypertension, bronchiectasis, or other known active pulmonary diseases)? [If yes, no further questions.]	Yes	No
42	Has the patient tried and failed or had an inadequate response to a maximum tolerated dose of one of the following dual therapies (long-acting muscarinic antagonist [LAMA] plus long-acting beta-agonist [LABA]): A) Anoro Ellipta, B) Bevespi Aerosphere, C) Stiolto Respimat? [If no, no further questions.]	Yes	No
43	Has the patient tried and failed or had an intolerance to Trelegy Ellipta? [If no, no further questions.]	Yes	No
44	Is there documentation of at least 2 symptomatic exacerbations within the last year while compliant with Triple therapy (Trelegy Ellipta) for AT LEAST 3 months or has the patient experienced at least 1 exacerbation requiring hospitalization in the past 12 months? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
45	Has documentation been provided to confirm that the patient had an intolerance, contraindication to, or failed treatment with Roflumilast for at least 3 months, or have an FEV1 greater than 50%? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
46	Does the provider attest that the patient will continue maintenance therapy in combination with Ohtuvayre? [If no, no further questions.]	Yes	No
47	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the requested medication? [Note: Dosing: 3 mg via oral inhalation twice daily.]	Yes	No

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

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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 authorization as per Plan policy and procedures.

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

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