TRICARE Prior Authorization Request Form for
fluticasone/salmeterol HFA **(Advair HFA)**

JOHNS HOPKINS
HEALTH PLANS
7231 Parkway Drive, Suite 100, Hanover, MD 21076

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Note: PA criteria do not apply to children younger than 12 years of age.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____

Address: _____ Address: _____

_____ _____

Sponsor ID # _____ Phone #: _____

Date of Birth: Secure Fax #:

Step 2 Please complete the clinical assessment:

1. **The provider acknowledges that generic fluticasone/salmeterol diskus (for example, Wixela and other generics) and generic budesonide/formoterol (Symbicort) are available without requiring prior authorization and the provider should consider writing for generic fluticasone/salmeterol diskus or generic budesonide/formoterol instead.**	☐ Acknowledged Proceed to question 2	
2. **The provider acknowledges that if the patient requires an hydrofluoroalkane (HFA) inhaler that generic budesonide/formoterol (Symbicort) is an HFA inhaler and the provider should consider writing for generic budesonide/formoterol instead.**	☐ Acknowledged Proceed to question 3	
3. **Has the patient experienced significant adverse effects from generic fluticasone/salmeterol diskus that is not expected to occur with brand Advair HFA?**	☐ Yes Sign and date below	☐ No Proceed to question 4
4. **Has the patient had an inadequate response to generic fluticasone/salmeterol diskus?**	☐ Yes Sign and date below	☐ No Proceed to question 5
5. **Has the patient previously responded to Advair HFA and changing to fluticasone/salmeterol diskus would incur unacceptable risk?**	☐ Yes Sign and date below	☐ No STOP Coverage not approved

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____

Prescriber Signature Date

[28 Feb 2024]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: