TRICARE Prior Authorization Request Form for
Fluticasone/salmeterol (AirDuo Respiclick)

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HEALTH PLANS
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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.

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 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. **Does the patient have a diagnosis of asthma?** Note: Non-FDA-approved uses are NOT approved, including for chronic obstructive pulmonary disease (COPD).	☐ Yes Proceed to question 3	☐ No **STOP** **Coverage not approved**
3. **Does the patient require salmeterol as the long-acting beta agonist (LABA) and require a lower salmeterol dose than found in AirDuo vs. generic fluticasone/salmeterol diskus (for example, Wixela)?**	☐ Yes **Sign and date below**	☐ No Proceed to question 4
4. **Does the patient require fluticasone/salmeterol and cannot manipulate the generic fluticasone/salmeterol diskus (for example, Wixela) devices?**	☐ 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: