Prior Authorization Request Form for: **Inhaled Corticosteroids: Aerospan, Alvesco, Arnuity Ellipta, Asmanex HFA, Asmanex Twisthaler, Pulmicort Flexhaler, QVAR, QVAR Redihaler**

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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.

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. Which medication is requested?	☐ **Pulmicort Flexhaler** (budesonide) – **Proceed to question 2** ☐ **All others – Proceed to question 3**	
2. *(Pulmicort Flexhaler/ budesonide request)* **Is the patient a female who is pregnant?**	☐ Yes Sign and date below	☐ No Proceed to question 3
3. Has the patient tried Flovent Diskus or Flovent HFA and experienced an inadequate response or an intolerable adverse effect?	☐ Yes Sign and date below	☐ No Proceed to question 4
4. Does the patient have a contraindication to Flovent Diskus or Flovent HFA?	☐ Yes Sign and date below	☐ No Proceed to question 5
5. Has the patient previously responded to the requested agent and changing to Flovent would incur an unacceptable risk?	☐ Yes Sign and date below	☐ No Coverage not approved

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

_____ _____
Prescriber Signature Date

[14 February 2018]

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