Prior Authorization Request Form for
revefenacin **(Yupelri)**

JOHNS HOPKINS HEALTHCARE
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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:**

Question	Yes	No
1. Does the patient have a diagnosis of chronic obstructive pulmonary disease?	☐ Yes Proceed to question **2**	☐ No **STOP** Coverage not approved
2. Has the patient tried and failed an adequate course of a nebulized Short-Acting Muscarinic Antagonist (for example, ipratropium)?	☐ Yes Proceed to question **3**	☐ No **STOP** Coverage not approved
3. Has the patient tried and failed an adequate course of Spiriva Respimat?	☐ Yes Proceed to question **4**	☐ No **STOP** Coverage not approved
4. Has the patient tried and failed an adequate course of therapy with at least one of the following dry powder inhalers: Tudorza Pressair, Incruse Ellipta, Spiriva Handihaler, or Seebri Neohaler?	☐ Yes **Sign and date below**	☐ No Proceed to question **5**
5. Can the patient generate the peak inspiratory flow needed to activate at least one of the following dry powder inhalers: Tudorza Pressair, Incruse Ellipta, Spiriva Handihaler,or Seebri Neohaler?	☐ Yes **STOP** Coverage not approved	☐ No **Sign and date below**

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

______________________ Prescriber Signature ______________ Date

[29 May 2019]

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