Prior Authorization Request Form for
fluticasone/vilanterol **(Breo Ellipta)**

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
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.

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. Is the indication or diagnosis asthma?	☐ Yes Proceed to question 6	☐ No Proceed to question 2
2. Is the use of Advair Diskus (fluticasone/salmeterol) or Advair HFA contraindicated?	☐ Yes Sign and date below	☐ No Proceed to question 3
3. Has the patient experienced intolerable adverse effects to Advair Diskus or Advair HFA?	☐ Yes Sign and date below	☐ No Proceed to question 4
4. Has the patient had an inadequate response to Advair Diskus or Advair HFA?	☐ Yes Sign and date below	☐ No Proceed to question 5
5. Has the patient previously responded to the nonformulary agent and changing to Advair Diskus or Advair HFA would incur unacceptable risk?	☐ Yes Sign and date below	☐ No Coverage not approved
6. Is the patient 18 years of age or older?	☐ Yes Proceed to question 7	☐ No Coverage not approved
7. Has the patient experienced intolerable adverse effects to Advair Diskus or Advair HFA?	☐ Yes Sign and date below	☐ No Proceed to question 8
8. Has the patient had an inadequate response to Advair Diskus or Advair HFA?	☐ 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

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