Prior Authorization Request Form for
budesonide/formoterol **(Symbicort)**, mometasone/formoterol **(Dulera)**

JOHNS HOPKINS MEDICINE
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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. Is the use of Advair Diskus *(fluticasone/salmeterol)* **or Advair HFA contraindicated?**	☐ Yes **Sign and date below**	☐ No Proceed to question **2**
2. Has the patient experienced intolerable adverse effects to Advair Diskus or Advair HFA?	☐ Yes **Sign and date below**	☐ No Proceed to question **3**
3. Has the patient had an inadequate response to Advair Diskus or Advair HFA?	☐ Yes **Sign and date below**	☐ No Proceed to question **4**
4. Has the patient previously responded to the requested medication and changing to Advair Diskus or Advair HFA would incur unacceptable risk?	☐ Yes **Sign and date below**	☐ No Proceed to question **5**
5. Does the patient have asthma and requires rescue therapy with an inhaled corticosteroid-formoterol combination in accordance with GINA Strategy?	☐ 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

[08 April 2020]

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