OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Advair® Diskus & Advair® HFA Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:
- ❑ Asthma
- ❑ Chronic obstructive pulmonary disease (COPD) [**Advair Diskus** only]
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

ASTHMA:

Select the medications the patient has a failure, contraindication, or intolerance to:
- ❑ Asmanex HFA
- ❑ Asmanex Twisthaler 30 metered doses, Asmanex Twisthaler 60 metered doses, Asmanex Twisthaler 120 metered doses
- ❑ Breo Ellipta
- ❑ Dulera
- ❑ Flovent Diskus
- ❑ Flovent HFA
- ❑ Fluticasone propionate-salmeterol
- ❑ Pulmicort Flexhaler
- ❑ Qvar Redihaler
- ❑ Symbicort

For Advair Diskus requests, also answer the following:
Does the patient have a history of failure, contraindication, or intolerance to Advair HFA? ❑ **Yes** ❑ **No**

COPD:

Select the medications the patient has a failure, contraindication, or intolerance to:

❑ Anoro Ellipta	❑ Incruse Ellipta	❑ Stiolto Respimat
❑ Arcapta Neohaler	❑ Serevent Diskus	❑ Striverdi Respimat
❑ Bevespi Aerosphere	❑ Spiriva Handihaler	❑ Symbicort
❑ Breo Ellipta	❑ Spiriva Respimat	❑ Tudorza

Quantity limit requests:
What is the quantity requested per MONTH? _____

What is the reason for exceeding the plan limitations?
- ❑ Titration or loading-dose purposes
- ❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
- ❑ Requested strength/dose is not commercially available
- ❑ There is a medically necessary justification why the patient cannot use a higher commercially available strength to achieve the same dosage and remain within the same dosing frequency. **Please specify**: _____
- ❑ Other: _____

Advair® Diskus & Advair® HFA Prior Authorization Request Form (Page 2 of 2)

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Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.