



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

Pulmicort Flexhaler® Prior Authorization Request Form
DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)	Provider Information (required)
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Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:		Strength:	Dosage Form:
<input type="checkbox"/> Check if requesting brand		Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy			

Clinical Information (required)

Select the diagnosis below:

Asthma

Other diagnosis: _____ ICD-10 Code(s): _____

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

Asthma:

Arnuity Ellipta

ArmonAir RespiClick 55, ArmonAir RespiClick 113, ArmonAir RespiClick 232

Asmanex HFA

Asmanex TwisThaler 30 metered doses, Asmanex TwisThaler 60 metered doses, Asmanex TwisThaler 120 metered doses

Flovent Diskus

Flovent HFA

Qvar

Qvar RediHaler

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: _____

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.