



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

Trelegy Ellipta Prior Authorization Request Form

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

Member Information (required)			Provider Information (required)		
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)												
<p>Select the diagnosis below:</p> <input type="checkbox"/> Chronic obstructive pulmonary disease (COPD), including chronic bronchitis and/or emphysema <input type="checkbox"/> Reduce exacerbations of COPD in patients with a history of exacerbations <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____												
<p>Select the medications the patient has a failure, contraindication, or intolerance to:</p> <table border="0"> <tr> <td><input type="checkbox"/> Advair Diskus</td> <td><input type="checkbox"/> Serevent Diskus</td> </tr> <tr> <td><input type="checkbox"/> Anoro Ellipta</td> <td><input type="checkbox"/> Spiriva Handihaler</td> </tr> <tr> <td><input type="checkbox"/> Arcapta Neohaler</td> <td><input type="checkbox"/> Spiriva Respimat</td> </tr> <tr> <td><input type="checkbox"/> Bevespi Aerosphere</td> <td><input type="checkbox"/> Stiolto Respimat</td> </tr> <tr> <td><input type="checkbox"/> Breo Ellipta</td> <td><input type="checkbox"/> Striverdi Respimat</td> </tr> <tr> <td><input type="checkbox"/> Incruse Ellipta</td> <td><input type="checkbox"/> Symbicort</td> </tr> </table>	<input type="checkbox"/> Advair Diskus	<input type="checkbox"/> Serevent Diskus	<input type="checkbox"/> Anoro Ellipta	<input type="checkbox"/> Spiriva Handihaler	<input type="checkbox"/> Arcapta Neohaler	<input type="checkbox"/> Spiriva Respimat	<input type="checkbox"/> Bevespi Aerosphere	<input type="checkbox"/> Stiolto Respimat	<input type="checkbox"/> Breo Ellipta	<input type="checkbox"/> Striverdi Respimat	<input type="checkbox"/> Incruse Ellipta	<input type="checkbox"/> Symbicort
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<p>Quantity limit requests: What is the quantity requested per MONTH? _____</p> <p>What is the reason for exceeding the plan limitations?</p> <input type="checkbox"/> Titration or loading-dose purposes <input type="checkbox"/> 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) <input type="checkbox"/> Requested strength/dose is not commercially available <input type="checkbox"/> 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: _____ <input type="checkbox"/> 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.

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