



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

Tudorza Pressair® Prior Authorization Request Form

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

Member Information <small>(required)</small>			Provider Information <small>(required)</small>		
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 <small>(required)</small>			
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 <small>(required)</small>
<p>Select the diagnosis below:</p> <input type="checkbox"/> Chronic obstructive pulmonary disease (COPD) <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____
<p>Select the medications the patient has a failure, contraindication, or intolerance to:</p> <input type="checkbox"/> Advair Diskus <input type="checkbox"/> Anoro Ellipta <input type="checkbox"/> Arcapta Neohaler <input type="checkbox"/> Bevespi Aerosphere <input type="checkbox"/> Breo Ellipta <input type="checkbox"/> Incruse Ellipta <input type="checkbox"/> Serevent Diskus <input type="checkbox"/> Spiriva Handihaler <input type="checkbox"/> Spiriva Respimat <input type="checkbox"/> Stiolto Respimat <input type="checkbox"/> Striverdi Respimat <input type="checkbox"/> Symbicort
<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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