



This form is based on Express Scripts standard criteria and may not be applicable to all patients; certain plans and situations may require additional information beyond what is specifically requested.

Additional forms available: [www.express-scripts.com/pa](http://www.express-scripts.com/pa)

Fax completed form to **1-800-357-9577**

If this an **URGENT** request, please call 1-800-417-8164

**Patient Information**

Patient First Name: \_\_\_\_\_

Patient Last Name: \_\_\_\_\_

Patient ID#: \_\_\_\_\_

Patient DOB: \_\_\_\_\_

Patient Phone #: \_\_\_\_\_

**Prescriber Information**

Prescriber Name: \_\_\_\_\_

Prescriber DEA/NPI (required): \_\_\_\_\_

Prescriber Phone #: \_\_\_\_\_

Prescriber Fax #: \_\_\_\_\_

Prescriber Address: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Primary Diagnosis: \_\_\_\_\_ ICD Code: \_\_\_\_\_

**Please indicate which drug and strength is being requested:**

- Advair Diskus 100mcg-50mcg/actuation Powder for Inhalation
- Advair Diskus 250mcg-50mcg/actuation Powder for Inhalation
- Advair Diskus 500mcg-50mcg/actuation Powder for Inhalation
- Advair HFA 45mcg-21mcg/actuation Inhalation Aerosol
- Advair HFA 115mcg-21mcg/actuation Inhalation Aerosol
- Advair HFA 230mcg-21mcg/actuation Inhalation Aerosol
- Dulera 100mcg/5mcg/actuation Inhalation Aerosol
- Dulera 200mcg/5mcg/actuation Inhalation Aerosol
- Symbicort 160mcg-4.5mcg/actuation Inhalation Aerosol
- Symbicort 80mcg-4.5mcg/actuation Inhalation Aerosol

Directions for use (i.e. QD, BID, PRN & Qty): \_\_\_\_\_

**Please complete the clinical assessment:**

1. What is the indication or diagnosis?

- Asthma or RAD (reactive airway disease)
- Acute Bronchitis
- Chronic Bronchitis
- Emphysema
- Postinfectious cough (cough persisting after an acute respiratory infection has resolved)
- COPD (chronic obstructive pulmonary disease)
- All other indications or diagnoses: \_\_\_\_\_

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

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Prescriber Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Office Contact Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Based upon each patient's prescription plan, additional questions may be required to complete the prior authorization process. If you have any questions about the process or required information, please contact our prior authorization team at the number listed on the top of this form.

Prior Authorization of Benefits is not the practice of medicine or a substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for the patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions.

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