



**Prior Authorization Form**  
**Combination Inhaled Corticosteroids and Long-Acting  $\beta$ -agonists**  
**Advair® Symbicort®**  
**Customer Service (401)-459-6020, Fax (866)-423-0945**

Please complete the following information:      Date of Request: \_\_\_/\_\_\_/\_\_\_

<b>Member Name:</b> (required)	<b>Member ID Number, otherwise SSN#:</b> (required) <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>
<b>Member Date of Birth:</b> (required)    /    /	<b>Member Sex:</b> M      F      (Circle One)
<b>Prescriber Name:</b> (required) <b>Prescriber Specialty:</b> (required)	<b>Contact Person at Office:</b>
<b>Tel # &amp; extension:</b> (required) (    ) -	<b>Office Fax Number:</b> (required) (    ) -

In its most recent guidelines for Stepwise Approach to Managing Asthma in Adults and Children the NHLBI recommends that combination ICS + LABA products should generally be reserved for Step 3 (or higher) treatment following the failure of ICS controller therapy. Only if a patient presents with symptoms consistent with those described as either “MODERATE PERSISTENT” or “SEVERE PERSISTENT” is an ICS+LABA combination product recommended as INITIAL therapy.

**\*\*IF YOUR PATIENT HAS PREVIOUSLY OBTAINED ADVAIR OR SYMBICORT AND COVERAGE IS NOW BEING REJECTED AT THE PHARMACY, IT IS BECAUSE NEIGHBORHOOD HAS NO RECORD OF THE PATIENT FILLING EITHER AN ICS OR ICS+LABA PRODUCT IN THE LAST 90 DAYS.\*\***

Please check boxes below as appropriate:

**DRUG REQUESTED:**     Advair®     Symbicort®

Prescriber is a Board certified Pulmonologist or Allergist

Patient presents with Moderate Persistent or Severe Persistent Symptoms:  
(e.g. DAILY symptoms requiring use of short-acting  $\beta$ -agonist or some limitation of activity.)

Patient has Mild Persistent Asthma (e.g. symptoms > 2 times per week requiring use of short-acting  $\beta$ -agonist or minor limitation of activity) and has **failed to achieve an adequate clinical outcome or experienced side effects/intolerance** following a trial of an appropriate dose and duration of therapy with the Formulary agents listed below. **Please indicate all generic and Formulary agents this patient has previously tried:**

Drug	Dose	Inadequate outcome	Date	Side effect	Description of Side Effect
Flovent HFA		<input type="checkbox"/>		<input type="checkbox"/>	
Qvar		<input type="checkbox"/>		<input type="checkbox"/>	
Pulmicort		<input type="checkbox"/>		<input type="checkbox"/>	
Budesonide		<input type="checkbox"/>		<input type="checkbox"/>	
Other:		<input type="checkbox"/>		<input type="checkbox"/>	

Proper inhaler technique has been verified.

If approval criteria are met, Neighborhood will authorize coverage of Advair/Symbicort for 3 months during which potential step-down therapy should be assessed. **The patient’s compliance with therapy will ensure continued coverage.** Should a patient not refill the medication within 90 days, he/she will be subject to the step-edit again.

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber’s Signature \_\_\_\_\_ NPI \_\_\_\_\_

Completed form must be faxed to  
**Neighborhood Customer Service at 1-866-423-0945.**