

Inhaled Corticosteroids - Arizona

Prior Authorization Request Form

Please complete this <u>entire</u> form and fax it to: 866-940-7328. If you have questions, please call 800-310-6826. This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.

Allow at least 24 hours for review.

Section A - Member Infor	mation								
First Name:	Last Name:		Member ID:						
Address:									
City:	State:	State:				ZIP Code:			
Phone:	DOB:	DOB:				Allergies:			
Primary Insurance Information	(if any):	•							
Is the requested medicati	ion: 🗆 New or 🗆	Continua	tion of Ther	apy? If continuation,	list sta	rt date: _			
Is this patient currently h	nospitalized?	yes □ No	If recently	discharged, list disc	harge	date:			
Section B - Provider Infor	mation								
First Name:		_	Last Name:		_	_	M.D./D.O.		
Address:			City:				ZIP code:		
Phone:	Fax:		NPI #:	NPI #: Spec			ecialty:		
Office Contact Name / Fax atte	ention to:								
Section C - Medical Inforn	mation								
Medication:							Strength:		
Directions for use:							Quantity:		
Diagnosis (Please be specific & provide as much information as possible):							ICD-10 CODE:		
Is this member pregnant?		If yes	, w hat is this	member's due date?_					
Section D - Previous Med	ication Trials					Casses	far falling /		
Medication Name	Strength	Dire	ections Dates of Therap		Reason for failure / discontinuation				
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	†			1	\dashv				
Section E – Additional info	ormation and E	xplanation	of why pref	erred medications we	ould no	of meet th	e patient's needs:		
Section E – Additional info	Please refer to	the patien	t's PDL for	a list of preferred alte	ernative	es			



Provider Signature: _____

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Date: _____

Member First	name:	wember Last name:	Member DO	Б:			
Clinical and Drug Specific Information							
ALL REQUESTS							
□ Yes □ No	Does the patient have a	diagnosis of asthma?					
□ Yes □ No	Is there a history of failure, contraindication, or intolerance to a majority (not more than 3) of the preferred inhaled corticosteroids? (If yes, check which applies and complete Section D above) Asmanex Twisthaler (mometasone) Flovent HFA (fluticasone) Pulmicort Flexhaler (budesonide) Pulmicort Respule (budesonide) 1 mg (generic)						
BUDESONIDE RESPULES / BRAND PULMICORT RESPULES							
□ Yes □ No	Does the patient have a If yes, list reason:	reason or special circumsta	nce that they cannot us	e an inhaler device?			

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