

Inhaled Corticosteroids – Arizona Prior Authorization Request Form

Please complete this **entire** 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 Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance Information (if any):		
Is the requested medication: <input type="checkbox"/> New or <input type="checkbox"/> Continuation of Therapy? If continuation, list start date: _____		
Is this patient currently hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No If recently discharged, list discharge date: _____		

Section B - Provider Information

First Name:	Last Name:	M.D./D.O.
Address:	City:	State: ZIP code:
Phone:	Fax:	NPI #: Specialty:
Office Contact Name / Fax attention to:		

Section C - Medical Information

Medication:	Strength:
Directions for use:	Quantity:
Diagnosis (Please be specific & provide as much information as possible):	ICD-10 CODE:
Is this member pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what is this member's due date? _____	

Section D – Previous Medication Trials

Medication Name	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs: Please refer to the patient's PDL for a list of preferred alternatives

Member First name:		Member Last name:		Member DOB:	
Clinical and Drug Specific Information					
ALL REQUESTS					
<input type="checkbox"/> Yes <input type="checkbox"/> No		Does the patient have a diagnosis of asthma?			
<input type="checkbox"/> Yes <input type="checkbox"/> No		Is there a history of failure, contraindication, or intolerance to a <u>majority</u> (not more than 3) of the preferred inhaled corticosteroids? <i>(If yes, check which applies and complete Section D above)</i> <input type="checkbox"/> Asmanex Twisthaler (mometasone) <input type="checkbox"/> Flovent HFA (fluticasone) <input type="checkbox"/> Pulmicort Flexhaler (budesonide) <input type="checkbox"/> Pulmicort Respule (budesonide) 1 mg (generic)			
BUDESONIDE RESPULES / BRAND PULMICORT RESPULES					
<input type="checkbox"/> Yes <input type="checkbox"/> No		Does the patient have a reason or special circumstance that they cannot use an inhaler device? <i>If yes, list reason:</i>			

Provider Signature: _____ **Date:** _____

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