

BRONCHODILATORS, BETA AGONIST PRIOR AUTHORIZATION FORM

To review the prior authorization guidelines for Bronchodilators, Beta Agonist, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – **Bronchodilators, Beta Agonist** (accessible at: <http://www.dhs.pa.gov/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm>).

PRIOR AUTHORIZATION REQUEST INFORMATION		PRESCRIBER INFORMATION	
<input type="checkbox"/> New request <input type="checkbox"/> Additional info (PA#: _____) <input type="checkbox"/> Renewal request # of pages in request: _____		Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
RECIPIENT INFORMATION		Street address:	
Recipient Name:		Suite #:	City/state/zip:
Recipient ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Medication/dosage form requested (* these agents are only indicated for the treatment of COPD)

A. Oral formulation:	B. Nebulizer sol'n, short-acting:	C. Inhalers, short-acting:	D. Nebulizer solution, long-acting:	E. Inhalers, long-acting:
<input type="checkbox"/> albuterol tablet, XR tablet, syrup <input type="checkbox"/> metaproterenol tablet, syrup <input type="checkbox"/> terbutaline tablet <input type="checkbox"/> Vospire ER tablet	<input type="checkbox"/> albuterol 0.63 mg & 1.25 mg vials <input type="checkbox"/> levalbuterol concentrate sol'n <input type="checkbox"/> levalbuterol vials (all strengths) <input type="checkbox"/> Xopenex concentrate sol'n <input type="checkbox"/> Xopenex vials (all strengths)	<input type="checkbox"/> ProAir Respiclick <input type="checkbox"/> Xopenex HFA <input type="checkbox"/> Ventolin HFA	<input type="checkbox"/> Brovana vials* <input type="checkbox"/> Perforomist vials*	<input type="checkbox"/> Arcapta Neohaler* <input type="checkbox"/> Foradil Aerolizer <input type="checkbox"/> Serevent Diskus <input type="checkbox"/> Striverdi Respimat*

Strength:	Dosage form:	Directions:
Quantity:	Refills:	Diagnosis (<i>submit documentation</i>):
		Dx code (required):

Section A: Oral tablets/syrup requests

1. Has the Recipient tried and failed, or have a contraindication or intolerance to, the preferred inhaled beta agonist agents? *Check all that apply.*

<input type="checkbox"/> albuterol 2.5 mg/3ml nebulizer vials, albuterol 0.5% nebulizer concentrate solution, ProAir HFA, or Proventil HFA	<input type="checkbox"/> Advair <input type="checkbox"/> Dulera	<input type="checkbox"/> Symbicort	<input type="checkbox"/> Yes – <i>submit all supporting documentation of drug regimen and treatment outcome</i> <input type="checkbox"/> No
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2. Does the Recipient require the use of an ORAL agent (instead of an inhaled formulation)?

Yes – *submit medical record documentation supporting the need for an oral agent*
 No

Section B: Short-acting nebulizer solution requests

1. Has the Recipient's tried and failed, or have a contraindication or intolerance to, the preferred short-acting nebulizer solution, albuterol 2.5 mg /3 ml (0.083%) vials or albuterol 0.5% concentrate solution?

Yes – *submit all supporting documentation of drug regimen and treatment outcome*
 No

Section C: Short-acting inhaler requests

1. Has the Recipient's tried and failed, or have a contraindication or intolerance to, the preferred short-acting inhalers, ProAir HFA or Proventil HFA?

Yes – *submit all supporting documentation of drug regimen and treatment outcome*
 No

Section D: Non-preferred long-acting nebulizer solution and inhaler requests – COPD DIAGNOSIS

1. Has the Recipient tried and failed, or have a contraindication or intolerance to, the following long-acting beta-agonists?

<input type="checkbox"/> Foradil Aerolizer (or Perforomist nebulizer vials)	<input type="checkbox"/> Serevent Diskus	<input type="checkbox"/> Yes – <i>submit documentation of drug regimen and treatment outcome</i> <input type="checkbox"/> No
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Section E: Long-acting inhaler requests – ASTHMA DIAGNOSIS

1. Will the Recipient be using the requested agent in combination with an inhaled steroid?

Yes – *submit documentation of concurrent inhaled steroid use*
 No – *submit documentation supporting use of the requested agent WITHOUT a concurrent inhaled steroid*

2. Has the Recipient tried and failed, or have a contraindication or intolerance to, the following preferred long-acting steroid/beta-agonist combination products?

<input type="checkbox"/> Advair	<input type="checkbox"/> Dulera	<input type="checkbox"/> Symbicort	<input type="checkbox"/> Yes – <i>submit all supporting documentation of drug regimen and treatment outcome</i> <input type="checkbox"/> No
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PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	Date:
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