US Family Health Plan
Prior Authorization Request Form for
glycopyrrolate inhalation solution (**Lonhala Magnair**)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be **faxed** to **617-562-5296**

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Step 1 **Please complete patient and physician information** (please print):

Patient Name:		Physician Name:	
Address:		Address:	
Sponsor ID #		Phone #:	
Date of Birth:		Secure Fax #:	

Step 2 Please complete the clinical assessment:

1. Does the patient have a diagnosis of chronic obstructive pulmonary disease?	☐ Yes Proceed to question 2	☐ No **STOP** **Coverage not approved**
2. Has the patient tried and failed an adequate course of a nebulized Short Acting Muscarinic Antagonist (e.g. ipratropium)?	☐ Yes Proceed to question 3	☐ No **STOP** **Coverage not approved**
3. Has the patient tried and failed an adequate course of Spiriva Respimat?	☐ Yes Proceed to question 4	☐ No **STOP** **Coverage not approved**
4. Has the patient tried and failed an adequate course of therapy at least one of the following dry powder inhalers: Tudorza Pressair, Incruse Ellipta, Spiriva Handihaler, or Seebri Neohaler?	☐ Yes Sign and date below	☐ No Proceed to question 5
5. Is the patient able to generate the peak inspiratory flow needed to activate at least one of the following dry powder inhalers: Tudorza Pressair, Incruse Ellipta, Spiriva Handihaler, or Seebri Neohaler?	☐ Yes **STOP** **Coverage not approved**	☐ No Sign and date below

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

Prescriber Signature _____ Date _____

[22 August 2018]