US Family Health Plan
Prior Authorization Request Form for
budesonide/formoterol **(Symbicort)**, mometasone/formoterol **(Dulera)**

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 **855-273-5735**
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**

Note: PA criteria do not apply to children younger than 12 years. **usfamilyhealth.org/rx-pa**

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. Is the use of Advair Diskus *(fluticasone/salmeterol)* **or Advair HFA contraindicated?**	☐ Yes **Sign and date below**	☐ No Proceed to question **2**
2. Has the patient experienced intolerable adverse effects to Advair Diskus or Advair HFA?	☐ Yes **Sign and date below**	☐ No Proceed to question **3**
3. Has the patient had an inadequate response to Advair Diskus or Advair HFA?	☐ Yes **Sign and date below**	☐ No Proceed to question **4**
4. Has the patient previously responded to the requested medication and changing to Advair Diskus or Advair HFA would incur unacceptable risk?	☐ Yes **Sign and date below**	☐ No Proceed to question **5**
5. Does the patient have asthma and requires rescue therapy with an inhaled corticosteroid-formoterol combination in accordance with GINA Strategy?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

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

Prescriber Signature _____ Date _____

[08 April 2020]