

USFHP Prior Authorization Request Form for
budesonide/albuterol (Airsupra)

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

<https://www.usfamilyhealth.org/for-providers/pharmacy-information/>

Prior authorization does not expire. Clinical documentation may be required.

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. Provider acknowledges that generic budesonide/formoterol is available at the lowest copay and does not require a PA.	☐ Acknowledged Proceed to question 2	
2. Is the patient 18 years of age or older?	☐ Yes Proceed to question 3	☐ No STOP Coverage not approved
3. What is the indication or diagnosis?	☐ Asthma – Proceed to question 4 ☐ Other diagnosis – STOP – Coverage not approved	
4. Has the patient tried and failed rescue use of inhaled corticosteroid (ICS)/formoterol or albuterol plus a separate inhaled corticosteroid (ICS)?	☐ Yes Sign and date below	☐ No Proceed to question 5
5. Has the patient been receiving a medium to high-dose inhaled corticosteroid (ICS)/long-acting beta-agonist (LABA) OR inhaled corticosteroid (ICS) with long-acting muscarinic antagonist (LAMA) for AT LEAST 3 months using spacer and appropriate technique AND has demonstrated inadequate symptom control with frequent exacerbations and/or night-time awakenings?	☐ Yes Sign and date below	☐ No Proceed to question 6

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6. Does the patient have a documented allergic reaction (for example, anaphylaxis) to formoterol?

☐ 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

[29 September 2026]