US Family Health Plan

Prior Authorization Request Form for:

Inhaled corticosteroids : Aerospan, Alvesco, Arnuity, Asmanex HFA and Twisthaler Pulmicort Flexihaler, Qvar and QVAR Redihaler

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: Prior authorization criteria applies for patients who are older than 12 years.

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. Which medication is requested?	☐ **Pulmicort Flexhaler** (budesonide) – **Proceed to question 2** ☐ **All others** – **Proceed to question 3**	
2. *(Pulmicort Flexhaler/ budesonide request)* **Is the patient a female who is pregnant?**	☐ Yes Sign and date below	☐ No Proceed to question 3
3. Has the patient tried fluticasone propionate and experienced an inadequate response or an intolerable adverse effect?	☐ Yes Sign and date below	☐ No Proceed to question 4
4. Does the patient have a contraindication to fluticasone propionate?	☐ Yes Sign and date below	☐ No Proceed to question 5
5. Has the patient previously responded to the requested drug and changing to fluticasone propionate would incur an unacceptable risk?	☐ Yes Sign and date below	☐ No Coverage not approved

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

Prescriber Signature _____ Date _____

[26 June 2024]