Advair®(fluticasone/salmeterol**) and Breo®(**fluticasone/vilanterol**)**

PRIOR AUTHORIZATION REQUEST FORM

For authorization, **please answer each question, include patient chart notes to document clinical information, and fax this form back to the PEHP Prior Authorization Department at (801) 245-7774** or mail to: PEHP Pharmacy services, 560 East 200 South Salt Lake City, UT 84102. If you have prior authorization questions, you may phone the PEHP Customer Service at (801) 366-7551.

1. Date:	2. Patient Name:	3. ID #:
4. D.O.B:	5. Physician:	6. Office Phone:
7. Office Fax:	8. Office Contact:	9. Dose Request:
10. Sex:	11. Weight:	

Authorization is requested from: to

Question	Yes	No	Comments/Notes
12. Select medication you are requesting: ☐ Advair® Diskus® ☐ Advair® HFA ☐ Breo® Ellipta®			
13. Is the patient ≥ 4 years of age?			
14. If the request is for **Advair®**, is the diagnosis documented as asthma or COPD?			
15. If the request is for **Breo®**, is the diagnosis documented as COPD?			
16. Has the patient had a trial or intolerance to one of the following: Symbicort® or Dulera®?			Verification will be made by reviewing the patient's drug history or chart notes.
17. If the request is for continued treatment with Advair® or Breo® is there improvement in FEV1, decreased exacerbations, or improved quality of life?			Documentation is required.

18. Physician's Signature: ______________________________

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