

CONTAINS CONFIDENTIAL PATIENT INFORMATION
Advair Duplicate Therapy (fluticasone/salmeterol)
Complete form in its entirety and fax to:
Prior Authorization of Benefits (PAB) Center at (866) 807- 6241

1. PATIENT INFORMATION

2. PHYSICIAN INFORMATION

| | |
|------------------------------|--------------------------------|
| Patient Name: _____ | Prescribing Physician: _____ |
| Patient ID #: _____ | Physician Address: _____ |
| Patient DOB: _____ | Physician Phone #: _____ |
| Date of Rx: _____ | Physician Fax #: _____ |
| Patient Phone #: _____ | Physician Specialty: _____ |
| Patient Email Address: _____ | Physician DEA: _____ |
| | Physician NPI #: _____ |
| | Physician Email Address: _____ |

3. MEDICATION

4. STRENGTH

5. DIRECTIONS

6. QUANTITY PER 30 DAYS

| | | | |
|------------------------------------|--------------------------------|-------|----------------|
| Advair (salmeterol/fluticasone) | <input type="checkbox"/> _____ | _____ | Specify: _____ |
|------------------------------------|--------------------------------|-------|----------------|

7. DIAGNOSIS: _____

8. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY

NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.

Please provide verification of intent for the patient to be on both Advair and an inhaled corticosteroid or Advair and Serevent or Advair and Foradil together:

9. PHYSICIAN SIGNATURE

| | |
|---|---------------|
| _____ Prescriber or Authorized Signature | _____ Date |
|---|---------------|

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

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