



Prior Authorization Request Form for Beta-Agonist Bronchodilator

FAX this completed form to (844) 205-3386

OR Mail requests to: Pharmacy Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720

OR Prior authorization may be completed at <https://www.covermyeds.com/main/prior-authorization-forms/>

I. PROVIDER INFORMATION		II. MEMBER INFORMATION	
Prescriber Name:		Member Name:	
Prescriber Specialty:		Identification #:	
NPI:		Group #:	
Office Contact Name:		Date of Birth:	
Fax #:		Medication Allergies:	
Phone #:			
III. DRUG INFORMATION (One drug request per form)			
Drug name and strength:	Dosage Interval (sig):	Qty. per Day:	
IV. REQUIRED DOCUMENTATION (Detailed medical record documentation demonstrating evidence for each item must be submitted with prior authorization request)			
Specify diagnosis & diagnosis code relevant to this request: _____ Dx/Dx Code: _____			
<input type="checkbox"/> If requesting for daily quantity exceeding daily limit (Refer to https://www.pahealthwellness.com/providers/pharmacy.html under PHW Quantity Limit List), please provide supporting information: _____			
Therapeutic Duplication: If concurrently prescribed a therapeutic duplicate (i.e. another beta agonist bronchodilator or dose different from the agent being requested):			
<input type="checkbox"/> is being transitioned from one beta agonist bronchodilator to another with the intent of discontinuing one of the medications			
<input type="checkbox"/> has a medical reason for concomitant use of the requested medications that is supported by peer-reviewed literature or national treatment guidelines: _____			
SUBMIT MEDICAL RECORD INFORMATION FOR EACH APPLICABLE ITEM.			
INITIAL REQUESTS:			
<input type="checkbox"/> For non-preferred short-acting inhaled beta agonist bronchodilators, does the member have a history of trial and failure of or contraindication or intolerance to the preferred short-acting inhaled beta agonist bronchodilators? Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred medications in this class.			
<input type="checkbox"/> For non-preferred long-acting inhaled beta agonist bronchodilators, does the member have a history of trial and failure of or contraindication or intolerance to the preferred long-acting inhaled beta agonist bronchodilators? Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred medications in this class.			
<input type="checkbox"/> For non-preferred oral beta agonist bronchodilators, does the member have a history of trial and failure of or contraindication or intolerance to the preferred inhaled bronchodilators? Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred medications in this class.			
RENEWAL REQUESTS:			
<input type="checkbox"/> Documentation of tolerability and has experienced a positive clinical response to requested medication evidenced by: _____			
IV. ADDITIONAL RATIONALE FOR REQUEST / PERTINENT CLINICAL INFORMATION :			

Appropriate clinical information to support the request on the basis of medical necessity must be submitted.	Provider Signature:	Date:

Pharmacy Department will respond via fax or phone within 24 hours.

Requests for prior authorization (PA) requests must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)