SCRIPTGUIDERX REQUEST FOR PRIOR AUTHORIZATION
STEP THERAPY - ADVAIR

Prescribing Physician:

Name:_____
First **Last**
Direct Phone #: (_ _ _) _____

Fax #: (_ _ _) _____

Physician specialty: _____

Patient:

Name:_____
First **Last**
ID#: _____

Phone #: _____**Group:**_____

Birth Date: _ _ - _ _ - _ _ _ _ **Sex:** ☐ **Female** ☐ **Male**

Name and title of person completing form (please print): _____

Drug name: **Strength:** **Administration Schedule:** **Length of Therapy:** **Quantity Requested:**

a)_____

Has patient been on this drug and, if yes, for how long at this dosage? _____

Patient's diagnosis requiring the use of this medication: _____

1. Previous history of a medical condition, allergies or other pertinent medical information that necessitates the use of this medication:

_____

2. Has the patient been seen by any other provider for this condition? ☐ **Yes** ☐ **No**
If so, what was the prescriber's specialty? _____

3. Previous non-prior authorized and prior authorized medications tried and failed for this condition:

Name of medication	Reason for failure	Date:
_____	_____	_ _/ _ _/ _ _ _ _
_____	_____	_ _/ _ _/ _ _ _ _
_____	_____	_ _/ _ _/ _ _ _ _

4. Pertinent laboratory test or procedure: (if applicable)

Procedure:	Findings:	Date:
_____	_____	_ _/ _ _/ _ _ _ _
_____	_____	_ _/ _ _/ _ _ _ _
_____	_____	_ _/ _ _/ _ _ _ _

**** Advair- please note if any of the following agents have been tried:**

Azmacort, Aerobid, Aerobid-M, Asmanex, Flovent, Pulmicort, Qvar

Fax Request to: ScriptGuideRX @ 313-264-0985

Date Received: Date Completed:	Decision (all authorizations are pending valid eligibility):

15400 E. Jefferson Avenue ♦ Grosse Pointe Park ♦ MI ♦ 48230 ♦ 313-499-3223, ext 207
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