



Date _____

Client _____

PRIOR AUTHORIZATION CRITERIA- ADVAIR DISKUS/HFA

M.D. Last Name: _____	M.D. First Name: _____
Physician Phone: _____	Physician Fax: _____
Patient _____	ID# _____ DOB _____

TO ENSURE PROMPT PROCESSING PLEASE COMPLETE ALL OF THE QUESTIONS.

1. For patients beginning therapy with Advair, please indicate patient's diagnosis (For Renewals, SKIP to #6):
 - Asthma
 - COPD associated with chronic bronchitis or emphysema
 - Reduction of exacerbations in patients with chronic COPD (**Advair 250/50 only**)
 - Other diagnosis: _____
 Note: If "Other" diagnosis is used, please attach a study with efficacy data supporting this request
2. Will the member use Advair as a chronic, maintenance medication, year-round? Yes No
3. Please list dates, and **attach chart notes** to document member's failure on an Inhaled Corticosteroid:

Drug Used/Failed: _____

Dates used: _____
4. Please list the medication and the last date that a short-acting beta agonist was ordered for this patient:

Drug Used/Date Ordered: _____
5. Does this member's disease severity clearly warrant treatment with 2 maintenance therapies? Yes No
6. For renewals, Advair is grandfathered for coverage if the member is using the medication chronically, as a maintenance medication. Since we do not have recent claims for this member, **please provide and attach chart notes** showing current use, AND, Is the member using Advair as a chronic, year-round, maintenance medication? Yes No
7. Is the member age 4 years or older? Yes No

NOTE: When member does not have supporting claims history in RESTAT's system, we require chart notes from the physician to document past medication use.

NOTE: On November 18, 2005, the FDA issued a Public Health Advisory to highlight recommendations about us of a long-acting beta-agonist (LABA) medicine for asthma, most notably: "LABA's should not be the first medicine used to treat asthma. LABA's should be added to the asthma treatment plan only if other medicines do not control asthma, including the use of low-or-medium dose corticosteroids".

Physician Signature or name of person providing answers _____

Physician Comments _____

Send or Fax completed form to:
877-329-7279

RESTAT
P.O. BOX 758
WEST BEND, WI 53095

QUESTIONS PLEASE CALL:
877-526-9906

www.restat.com