Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Beta-Adrenergics & Combinations Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 1 year; Continuation- 1 year

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Beta-Adrenergics & Combinations.** Please complete and fax this form back to Kaiser Permanente within 24 hours [fax: 1-866-331-2104]. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless this form is complete. The KP-MAS Formulary can be found at:** **http://pithelp.appl.kp.org/MAS/formulary.html**

1 – Patient Information

Patient Name: ______________________________ Kaiser Medical ID#: _________________ Date of Birth: _____________

2 – Provider Information

Provider Name: ______________________________ Provider NPI: ____________________________

Provider Address: ____

Provider Phone #: __________________________Provider Fax #: ___________________________

Please check the boxes that apply:

□Initial Request □ Continuation of Therapy Request

□ Standard Review (72 hours)

□ Expedited Review (24 hours): By checking this box, I certify that applying 72 hours standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Provider Signature____

3 – Pharmacy Information

Pharmacy Name: ________________________________ Pharmacy NPI: ____

Pharmacy Phone #_______________________________ Pharmacy Fax #: ____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: ____

Sig: ____

Drug 2: Name/Strength/Formulation: ____

Sig: ____

5 – Diagnosis

Patient Age:
□ < 18 years old   □ < 12 years old   □ < 5 years old   □ < 4 years old

Diagnosis:
□ Asthma   □ COPD

6 – Clinical Criteria

FDA Age-Approved Indications:

Adults > 18 years old – COPD only:
□ Anoro Ellipta   □ Arcapta Neohaler   □ Bevespi Aerosphere   □ Brovana
□ Perforomist   □ Stiolto Respimat   □ Striverdi Respimat

Adults > 18 years old – Asthma & COPD:
□ Breo Ellipta

Children > 12 years old – Asthma only:
□ Airduo Respiclick   □ Dulera   □ Fluticasone/Salmeterol

Children > 12 years old – Asthma & COPD:
□ Advair Diskus 250/50   □ Advair Diskus 500/50   □ Symbicort

Children > 5 years old – Asthma & COPD:
□ Foradil Aerolizer

Children > 4 years old – Asthma & COPD:
□ Advair Diskus 100/50   □ Serevent Diskus

Please provide the clinical rationale as to why the requested product is being used outside of FDA age-approved indications (shown above).

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7 – Provider Sign-Off

Additional Information – Please provide any additional information that should be taken into consideration.

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I certify that the information provided is accurate. Supporting documentation is available for State audits.

Provider Signature:	**Date:**
Please Note: This document contains confidential information, including protected health information, intended for a specific individual and purpose. The information is private and legally protected by law, including HIPAA. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any action in reliance on the contents of this telecopied information is strictly prohibited. Please notify sender if document was not intended for receipt by your facility	