| Prior Authorization Form GEHA FEDERAL - STANDARD OPTION Dulera (FA-PA) This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to CVS/Caremark at 1 988-836-0730 . Please contact CVS/Caremark at 1 982-840-0536 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Dulera (FA-PA). Drug Name (select from list of drugs shown) Dulera (mometasone-formoterol) Quantity Frequency Strength Strength Route of Administration Expected Length of Therapy Patient Information Patient Information Patient DB: | | | | |
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| City, State, Zip: | Physician Fax: | | | |
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| drug? [If yes, provide your patient with a new prescription | | | | |
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| Available Formulary Alternatives: ADVAIR, BREO ELLIPTA, SYMBICORT | Available For | rmulary Alternatives: ADVAIR, BREO ELLIP⊺ | TA, SYMBICORT | |
| 2. Is the requested drug being used for an FDA-Approved Y N | | | | |

indication OR an indication supported in the compendia of current literature (examples: AHFS, Micromedex, current accepted guidelines)?

| 3. | Does the prescribed dose and quantity fall within the FDA Y N approved labeling or within dosing guidelines found in the compendia of current literature? | |
|----|---|--|
| 4. | Has the patient tried and had an inadequate treatment response or intolerance to the required number of formulary alternatives: [If yes, then documentation is required for approval.] Drug Name Reason for Failure | |
| | Note: Formulary Alternatives should be prescribed first unless the patient is unable to use or receive treatment with the alternative. Required Formulary Alternatives: 3 in a class with only 3 alternative, ADVAIR, BREO ELLIPTA, SYMBICORT | |
| | [If yes, no further questions.] | |
| 5. | Does the patient have a contraindication to all the Y N alternatives? | |

I affirm that the information given on this form is true and accurate as of this date.

| Prescriber (Or Authorized) Signature and Date | | | |
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