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

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: _____

Diagnosis:

☐ Asthma ☐ COPD

6 – Clinical Criteria

FDA Age-Approved Indications:

Brand Name	Age where prior authorization is required	FDA Indications
Advair Diskus and Wixela 250/50 & 500/50	Children < 12	Asthma & COPD
Advair HFA	Children < 12	Asthma & COPD
Advair Diskus and Wixela 100/50	Children < 4	Asthma & COPD
Airduo Respiclick	Children < 12	Asthma only
Anoro Ellipta	Children & Adolescents < 18	COPD only
Arcapta Neohaler	Children & Adolescents < 18	COPD only
Bevespi Aerosphere	Children & Adolescents < 18	COPD only
Breo Ellipta	Children & Adolescents < 18	Asthma & COPD
Brovana	Children & Adolescents < 18	COPD only
Dulera 100/5 & 200/5	Children < 12	Asthma only
Dulera 50/5	Children < 5	Asthma only
Dupixent	Children < 12	Asthma only
fluticasone/salmeterol pow	Children < 12	Asthma only
Perforomist	Children & Adolescents < 18	COPD only
Serevent Diskus	Children < 4	Asthma & COPD
Stiolto Respimat	Children < 18 years	COPD only
Striverdi Respimat	Children < 18 years	COPD only
Symbicort 80/4.5	Children < 6	Asthma & COPD
Symbicort 160/4.5	Children < 12	Asthma & COPD

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

_____

_____

_____

7 – Provider Sign-Off

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

_____

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

Provider Signature:	**Date:**