# TeamstersCare Medication Prior Authorization Form

- Complete and fax to 617-241-5025.
- Standard response time is 3 to 5 business days from date received.

## Symbicort or Dulera

| PATIENT INFORMATION | |
|---|---|
| Patient Name: | |
| Date of Birth: | TeamstersCare ID#: |
| Patient Address: | Patient Phone: |

| PROVIDER INFORMATION | |
|---|---|
| Provider Name: | |
| Contact Person (If different than prescriber): | |
| Office Phone: | Office Fax: |

**Diagnosis**

Please describe: _____

**Please circle the appropriate answer.**

1. Is Advair Diskus, Advair HFA or Breo Ellipta contraindicated with this patient?

   YES (Please describe) _____ NO

2. Has the patient previously responded to Symbicort or Dulera and changing to Advair Diskus, Advair HFA or Breo Ellipta would incur intolerable effects?

   YES (Please describe) _____ NO

Doctor's Signature: Date:

| FOR TEAMSTERSCARE USE ONLY | |
|---|---|
| Eligibility Verified ☐ | **Notes:** |
| Program: Active/MSTS ☐ ERMP ☐ RRX☐ | |
| Medication Requires PA ☐ | |
| Prior PA? Yes☐ No ☐ If Yes, Date: | |
| Form Complete/Legible ☐ | |
| | |
| Authorized ☐ Pended ☐ Denied ☐ | |
| | |
| Patient Notified ☐ By: Date: | |
| Letter Sent ☐ By: Date: | **Reviewer :** **Date:** |