Prescriber Criteria Form Nebs-Asthma COPD 2024 PA Fax BD-8 v2 010124.docx Inhalation Solutions – Beta 2 Adrenergic Agonists And Anticholinergics And Corticosteroids And Mast Cell Stabilizers Albuterol Inhalation Solution/Accuneb (albuterol), Brovana (arformoterol tartrate), Cromolyn Inhalation Solution (cromolyn sodium), Duoneb (ipratropium/albuterol), Ipratropium Inhalation Solution (ipratropium bromide), Perforomist (formoterol), Pulmicort (budesonide), Xopenex (levalbuterol), Yupelri (revefenacin) Coverage Determination
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 **1-855-633-7673**. Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Inhalation Solutions – Beta 2 Adrenergic Agonists And Anticholinergics And Corticosteroids And Mast Cell Stabilizers.

Drug Name (select from list of drugs shown):

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Is the patient using the requested drug with a nebulizer? [If no, then no further questions.]Tech Note: Process thru part D if the following exist: IF the patient took the requested medication on his own in an outpatient setting (e.g., emergency room, urgent care facility) for a reason not related to the visit, then apply one time approval for date of fill.)	Yes	No
2	Is the requested drug being prescribed for the management of asthma or obstructive pulmonary disease (including COVID-related respiratory conditions) associated with any of the following ICD-10 diagnosis codes: J12.82, J41.0, J41.1, J41.8, J42, J43.0-J43.2, J43.8, J43.9, J44.0, J44.1, J44.81, J44.89, J44.9, J45.20-J45.22, J45.30-J45.32, J45.40-J45.42, J45.50-J45.52, J45.901, J45.902, J45.909, J45.990, J45.991, J45.998, J47.0, J47.1, J47.9, J60, J61, J62.0, J62.8, J63.0-J63.6, J64, J65, J66.0-J66.2, J66.8, J67.0-J67.9, J68.0-J68.4, J68.8, J68.9, J69.0, J69.1, J69.8, J70.0-J70.5, J70.8, J70.9, U07.1, U09.9?Tech Note: Process thru part D if the following exist: IF the patient took the requested medication on his own in an outpatient setting (e.g. emergency room, urgent care facility) for a reason not related to the visit, apply one time approval for date of fill.)	Yes	No

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.
Prescriber (or Authorized) Signature: _____ Date:_____