PRIORITY PARTNERS
7231 Parkway Dr., Suite 100
Hanover, MD 21076

JOHNS HOPKINS
HEALTH PLANS

Prior Authorization

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Trelegy Ellipta - Priority Partners MCO

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Johns Hopkins Health Plans at **1-410-424-4607**.
Please contact Johns Hopkins Health Plans at **1-888-819-1043** with questions regarding the Prior Authorization process.
When conditions are met, we will authorize the coverage of Trelegy Ellipta - Priority Partners MCO.

Drug Name (select from list of drugs shown)
Trelegy Ellipta ((fluticasne-umeclidnm-vilantrl)

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician
Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Is this request for continuation of therapy? Y N

[Note: The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.]

[If no, then skip to question 3.]

2. Is there documentation showing the patient has had an improvement in symptoms with treatment? Y N

	[Note: Documentation must be submitted.]		
	[No further questions.]		
3.	Does the patient have any of the following: A) Severe hypersensitivity to milk proteins, or any ingredients, B) Any indications or uses that are not FDA-approved, or guideline-supported?	Y N	
	[If yes, then no further questions.]		
4.	Is the patient 18 years of age or older?	Y N	
	[If no, then no further questions.]		
5.	Does the patient have a documented diagnosis of chronic obstructive pulmonary disease (COPD), including chronic bronchitis and/or emphysema?	Y N	
	[Note: Documentation must be submitted.]		
	[If no, then skip to question 9.]		
6.	Does the patient have documentation showing a history of one or more moderate to severe exacerbations in the previous 12 months?	Y N	
	[Note: Documentation must be submitted.]		
	[If no, then no further questions.]		
7.	Does the patient have a documented trial and inadequate response to one of the following formulary combination therapies: A) Fluticasone-salmeterol (generic formulation of AirDuo), B) Anoro Ellipta (umeclidinium-vilanterol), C) Budesonide-formoterol (generic formulation of Symbicort)?	Y N	
	[Note: Documentation must be submitted.]		
	[If no, then no further questions.]		
8.	Does the patient have documentation showing Trelegy Ellipta is not being prescribed for higher than 100-62.5-25mcg once daily?	Y N	
	[Note: Documentation must be submitted.]		
	[No further questions.]		
9.	Does the patient have a documented diagnosis of uncontrolled asthma?	Y N	
	[Note: Documentation must be submitted.]		
	[If no, then no further questions.]		
10.	Is the diagnosis evidenced by at least one of the following in the previous 12 months: A) Temporary therapy adjustment for acute asthma symptoms, B) Healthcare contact for acute asthma symptoms?	Y N	
	[Note: Documentation must be submitted.]		
	[If no, then no further questions.]		
11.	Does the patient have a documented trial and inadequate response to one of the following formulary combination therapies: A) fluticasone-salmeterol (generic formulation of	Y N	

AirDuo), B) budesonide-formoterol (generic formulation of Symbicort)?		
[Note: Documentation must be submitted.]		
[If no, then no further questions.]		
12. Does the patient have documentation showing Trelegy Ellipta is not being prescribed for higher than 200-62.5-25mcg once daily?	Y N	
[Note: Documentation must be submitted.]		

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date