

PRIOR AUTHORIZATION REQUEST FORM

Airsupra

For authorization, please answer each question and fax this form PLUS chart notes back to RealRx Medicaid Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call Pharmacy Customer Service for assistance.

- Healthy U: 855-856-5694
- Healthy U CHIP: 855-203-3633
- Health Choice Utah: 855-864-1404

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:

Height/Weight:

Product Requested: Airsupra (albuterol/budesonide)

Directions for Use: _____

Criteria for Approval (ALL of the following criteria must be met):	Yes	No
1. Is the patient 18 years of age or older?	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the patient have a diagnosis of asthma?	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the patient had an inadequate response, intolerance, or contraindication to a minimum 7 day trial of a formoterol-inhaled corticosteroid (ICS) combination product (such as Dulera or Symbicort), used for as-needed symptom relief? Formoterol/ICS Product: _____ Dates of Therapy: _____ Details of Failure: _____	<input type="checkbox"/>	<input type="checkbox"/>
4. Has the patient demonstrated to the provider that they are able to perform proper inhaler technique?	<input type="checkbox"/>	<input type="checkbox"/>

Reauthorization

1. Has the provider submitted an updated letter with medical justification and updated chart notes demonstrating positive clinical response?	<input type="checkbox"/>	<input type="checkbox"/>
--	--------------------------	--------------------------

PRESCRIBER CERTIFICATION

I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

Physician's Signature:	Date:
------------------------	-------

Initial Authorization: Up to one (1) year

Reauthorization: Up to one (1) year

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy: PHARM-HYB-171
Origination Date: 01/01/2026
Reviewed/Revised Date:
Next Review Date:
Current Effective Date: 01/01/2026

Confidentiality Notice

This document and any accompanying document contain confidential information and is intended for the use of the individual or entity named on this transmission sheet. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or the taking of any action in reliance on the contents of this information is strictly prohibited and the document should be returned to this office immediately. If you have received this facsimile in error, please notify us by telephone immediately and destroy document received.