

Respiratory

Call: (877) 883-1392 Fax: (256) 429-2221

				Gender: OM OF Last o: Phone:			
				Allergies: ONo Known			
				S:Allergies. ONO Known			
te zip	NF1.	F	-none	Fax: Office	Contact		
tement of Medica	al Necessity (Please	Attach All Medical Docu	umentation)				
te of Diagnosis:	ICD-10: _			Other:	Da	ite:	
				Prior Failed	Drug Name	e & Lengt	th of
Diagnosis of Mod-Sev Asthma in patients > 12 Years Old:				Treatments	Trea	atment	
Diagnosed by: O Endoscopy O CT Scan Assessment: O Moderate O Mod to Severe O S			Sovoro	O Biologics			
	kacerbations in the la		J Severe	O ICS			
		its, or hospitalization:		O ICS + LABA			
				O Intranasal			
		Test Date: _ Test Date:		Corticosteroids			
IgE Level (if atopic comorbidities): Test Date: Pulmonary Function Test Results:				O LABA			
Pre-Bronchodilator FEV1: Test Date:				O Oral		_	
FeNO Levels (if applicable) Test Date: Test Date:				Corticosteroids			
	~~~~~~	rest bate.		O Other Controllers			
				O Sinus Surgery			
Diagnosis of chronic rhinosinusitis with nasal polyposis (CRSwNP) in patients >18 years old:						lame & Length Treatment	
	Diagnosed by: O Rhinoscopy O Nasal Endoscopy O C					Heaunen	
		Nasal Endoscony	O CT Scan	O Oral Corticosteroids		reatmen	
Diagnosed by:	O Rhinoscopy	O Nasal Endoscopy	O CT Scan	O Oral Corticosteroids O Intranasal Corticosteroids		reatmen	
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other things. Participation in this program is not a guarantee of prior authorization or of payment.

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Prior authorization approval and insurance benefits will be determined by the payor based upon the patient's eligibility, medical necessity, and the terms of the patient's coverage, among

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