

LEUKOTRIENE MODIFIERS PRIOR AUTHORIZATION FORM

- Please complete all applicable sections of this prior authorization request form and return to the fax number above. Please include all requested documentation (chart notes, laboratory data, etc.).
- To review the prior authorization guidelines for Leukotriene Modifiers, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – **Leukotriene Modifiers** (accessible at: <http://www.dhs.pa.gov/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm>).

PRIOR AUTHORIZATION REQUEST INFORMATION		PRESCRIBER INFORMATION	
<input type="checkbox"/> New request <input type="checkbox"/> Additional info (PA#: _____) <input type="checkbox"/> Renewal request # of pages in request: _____		Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
RECIPIENT INFORMATION		Street address:	
Recipient Name:		Suite #:	City/state/zip:
Recipient ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Non-preferred medication requested: <input type="checkbox"/> Accolate tablet* <input type="checkbox"/> Singulair granule* <input type="checkbox"/> Singulair chewable* <input type="checkbox"/> Zflo tablet* <input type="checkbox"/> montelukast granule <input type="checkbox"/> Singulair tablet* <input type="checkbox"/> zafirlukast tablet <input type="checkbox"/> Zflo CR tablet			
Strength:	Directions:	Quantity:	Refills:
Diagnosis:		DX code (required):	
1. Has the Recipient tried and failed the preferred Leukotriene Modifier, montelukast tablet or chewable tablet?		<input type="checkbox"/> Yes – <u>submit all supporting documentation of drug regimen and therapeutic failure</u> <input type="checkbox"/> No	
2. Does the Recipient have any contraindications or intolerances to the preferred agent listed in question (1)?		<input type="checkbox"/> Yes – <u>submit all supporting documentation of medication name(s) and associated intolerances / contraindications</u> <input type="checkbox"/> No	
3. For non-preferred brand name products with available generics (marked with a * in the above non-preferred medication list), why can't the Recipient take the FDA-approved generic equivalent product? <u>Include reason in space below and submit medical record documentation supporting the brand medically necessary request.</u>			

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	Date:
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