



Prior Authorization Request Form – Leukotriene Inhibitors

Instructions:

This form is to be used by participating providers to request coverage for Leukotriene Inhibitor medications requiring prior authorization. Please fill out this form COMPLETELY, including signature, and fax to MedMetrics Health Partners at 1-800-918-7542. Allow 24 hours to process request. Please call MedMetrics PA Line (available 24 hours a day) at 1-800-918-7550 for more urgent requests.

MedMetrics Health Partners – Prior Authorization Services
 P. O. Box 2586, Worcester, MA 01606

Phone: 1-800-918-7550
 Fax: 1-800-918-7542

A Leukotriene Inhibitor step therapy program has been developed to encourage the use of first-line therapies before second-line therapies are used for the same indication. If approved, quantity limits apply.

First-line therapies:

Single-entity Inhaled Corticosteroid products
 Combination Inhaled Corticosteroid products

Second-line therapies:

zafirlukast (Accolate)
 Singulair
 Zyflo
 Zyflo CR

Please PRINT and complete ALL of the following boxes:

| | | |
|------------------------|----------------------------|--------------------------------|
| 1. Member's FULL Name: | 2. Member's NHP ID Number: | 3. Member's DOB: (mm/dd/yy) |
|------------------------|----------------------------|--------------------------------|

| | |
|--|------------------------------|
| 4. Prescriber's FULL Name & Specialty: | 5. Contact Person at Office: |
|--|------------------------------|

| | | |
|---|---------------|---------------|
| 6. Prescriber's FAX & Telephone Number: Mailing Address: | Fax: () | Tel: () |
|---|---------------|---------------|

| | |
|--------------------|--|
| 7. Requested Drug: | 8. Dose, Frequency and Duration of Requested Drug: |
|--------------------|--|

| | |
|--|---|
| 9. Diagnosis/Indication: <input type="checkbox"/> Asthma or Reactive airway disease <input type="checkbox"/> Concomitant asthma & allergies/allergic rhinitis | <input type="checkbox"/> Exercise Induced Bronchoconstriction <input type="checkbox"/> Allergies/Allergic Rhinitis <input type="checkbox"/> Other: _____ |
|--|---|

| |
|--|
| 10. Is the member female and pregnant or breastfeeding? <input type="checkbox"/> Yes <input type="checkbox"/> No |
|--|

| |
|--|
| 11. Does the member have persistent asthma/reactive airway disease symptoms requiring daily maintenance therapy with a controller medication to control symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please specify: <input type="checkbox"/> Mild persistent disease <input type="checkbox"/> Moderate or severe persistent disease <input type="checkbox"/> Unknown |
|--|

| |
|--|
| 12. Is the member <u>currently</u> on a <u>combination</u> inhaled corticosteroid product (e.g., Advair, Symbicort, Dulera)? <input type="checkbox"/> Yes <input type="checkbox"/> No |
|--|

| |
|--|
| 13. Has the member had a trial of at least one <u>single-entity</u> ICS product <u>within the previous 3 months</u> ? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please specify which agent and the associated outcome of this trial: _____ |
|--|

| |
|--|
| 14. Has the member previously tried the following? |
|--|

| Drug Name (please check all that apply) | Response (please check all that apply) |
|--|--|
| <input type="checkbox"/> single entity-inhaled corticosteroid: _____ | <input type="checkbox"/> intolerance <input type="checkbox"/> inadequate response <input type="checkbox"/> allergy |
| <input type="checkbox"/> combination inhaled corticosteroid: _____ | <input type="checkbox"/> intolerance <input type="checkbox"/> inadequate response <input type="checkbox"/> allergy |
| <input type="checkbox"/> short acting beta agonist (please specify): _____ | <input type="checkbox"/> intolerance <input type="checkbox"/> inadequate response <input type="checkbox"/> allergy |
| <input type="checkbox"/> loratadine (Claritin/Alavert) | <input type="checkbox"/> side-effect <input type="checkbox"/> non-response <input type="checkbox"/> allergy |
| <input type="checkbox"/> cetirizine (Zyrtec) | <input type="checkbox"/> side-effect <input type="checkbox"/> non-response <input type="checkbox"/> allergy |
| <input type="checkbox"/> fexofenadine (Allegra) | <input type="checkbox"/> side-effect <input type="checkbox"/> non-response <input type="checkbox"/> allergy |
| <input type="checkbox"/> nasal steroid (please specify): _____ | <input type="checkbox"/> side-effect <input type="checkbox"/> non-response <input type="checkbox"/> allergy |
| <input type="checkbox"/> other (please specify): _____ | <input type="checkbox"/> side-effect <input type="checkbox"/> non-response <input type="checkbox"/> allergy |

| |
|--------------------------|
| 15. Prescriber comments: |
|--------------------------|

Signature:

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

 Prescriber's signature

 Date