



**PRIOR AUTHORIZATION FORM
Leukotriene Modifiers**

DATE OF REQUEST: _____

MEMBER INFORMATION

NAME _____

ID # _____

BIRTHDATE _____

PLEASE NOTE: By signing this form, you are attesting to the accuracy of the information provided, and that medical record documentation is available if requested.

PROVIDER INFORMATION

NAME _____

NPI # _____

ADDRESS _____

PHONE # _____ FAX # _____

CONTACT NAME _____

PROVIDER SIGNATURE _____

Drug Requested: **Singulair** (montelukast) **Accolate** (zafirlukast) **Zyflo CR** (zileuton)

Diagnosis _____ ICD-9 code _____

Please check one **Initial Request** **Extension Request**

Previous Medication History	Rationale for Discontinuation

Additional Information

Rationale for Request (co-morbidities, allergies, etc.) _____

Submit chart notes to identify all of the following:

- All other treatments have been tried
- Expected duration of requested treatment
- Outcome for each previous drug trial
- All other pertinent information

PLEASE NOTE: ALL CHART NOTES/LAB REPORTS IN REFERENCE TO THIS REQUEST MUST BE RECEIVED BEFORE A REVIEW CAN BEGIN. REQUESTS SUBMITTED WITHOUT THIS DOCUMENTATION MAY BE DENIED.

Refer to the MVP Formulary at www.mvphealthcare.com for those drugs that require prior authorization or are subject to quantity limits or step therapy.

FAX THIS REQUEST TO:

Commercial **1-800-376-6373**
(HMO, EPO/PPO, Option Child, Healthy NY, Personal Plan, CompCare, ASO)

Medicare Part D **1-800-401-0915**
(Preferred Gold, GoldAnywhere, GoldValue, USA Care, MVP RxCare)

Effective December 1, 2009