EXPRESS SCRIPTS®

Prior Authorization Form
Leukotriene Pathway Inhibitors Step Therapy

This form is based on Express Scripts standard criteria and may not be applicable to all patients; certain plans and situations may require additional information beyond what is specifically requested.
Additional forms available: www.express-scripts.com/pa

Fax completed form to **1-877-329-3760**
If this an **URGENT** request, please call 1-800-753-2851

Patient Information

Patient First Name: _____

Patient Last Name: _____

Patient ID#: _____

Patient DOB: _____

Patient Phone #: _____

Prescriber Information

Prescriber Name: _____

Prescriber DEA/NPI **(required)**: _____

Prescriber Phone #: _____

Prescriber Fax #: _____

Prescriber Address: _____

State: _____ Zip Code: _____

Primary Diagnosis: _____ ICD Code: _____

Please indicate which drug and strength is being requested:

- ☐ Accolate 10mg
- ☐ Accolate 20mg
- ☐ Singulair 4mg Chewable Tablet
- ☐ Singulair 4mg Granules
- ☐ Singulair 5mg Chewable Tablet
- ☐ Singulair 10mg
- ☐ Zyflo 600mg
- ☐ Zyflo 600mg Extended-Release

Directions for use (i.e. QD, BID, PRN & Qty):_____

Please complete the clinical assessment:			
1. Is the patient currently taking the requested medication?	☐ Yes	☐ No	☐ N/A
2. Is the patient taking samples or paying 100% out of pocket for the medication being requested? If no, please indicate: ☐ Requested medication covered under previous insurance plan ☐ Started medication in hospital ☐ Other: _____	☐ Yes	☐ No	☐ N/A

3. What is the indication or diagnosis?

- ☐ Allergic rhinitis
- ☐ Asthma or RAD (reactive airway disease)
- ☐ Other (please document): _____
  _____

4. Depending on the diagnosis, please indicate if the patient has been treated with any of the following:

☐ GENERIC Montelukast

☐ Nasal Antihistamine (i.e., azelastine, Astelin, Astepro, Patanase)
Please List: _____

_____

☐ Nasal Steroid (e.g. Nasonex, Flonase/fluticasone nasal spray, Nasacort AQ/ triamcinolone nasal spray, Nasarel/flunisolide nasal spray, Rhinocort, Beconase, Veramyst, Omnaris)
Please List: _____

_____

☐ Non-sedating or low-sedating antihistamine (i.e. cetirizine (Zyrtec), loratadine (Claritin), Clarinex, Xyzal, fexofenadine (Allegra), or their combination with pseudoephedrine)
Please List: _____

_____

☐ Beta-adrenergic agonist, oral inhaled corticosteroid, inhaled cromolyn/nedocromil
Please List: _____

_____

☐ GENERIC Zafirlukast

Are there any other comments, diagnoses, symptoms, and/or any other information the physician feels is important to this review?

_____

_____

_____

Prescriber Signature: _____Date: _____

Office Contact Name: _____ Phone Number: _____

Based upon each patient's prescription plan, additional questions may be required to complete the prior authorization process. If you have any questions about the process or required information, please contact our prior authorization team at the number listed on the top of this form.

Prior Authorization of Benefits is not the practice of medicine or a substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for the patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions.