

Leukotriene Modifiers

Prior Authorization Request (Physician to Complete)



Visit www.wellmark.com for the Wellmark Drug List for current medication tier levels and updated PA Forms

Facsimile Transmittal Sheet

Date: ____/____/____

To: Wellmark Pharmacy Services

From (Prescriber's Name): _____

Fax Number: (866) 884-4345

Prescriber's DEA Number: _____

Phone Number: (800) 600-8065

Prescriber's Phone Number: _____

Prescriber's Specialty: _____

Prescriber's Fax Number: _____

Prescriber's Office Address: _____
Street Suite # City State Zip

Patient Name: _____

Patient ID: _____ Patient DOB: ____/____/____

Please answer the following questions and fax this form back to (866) 884-4345. All fields are REQUIRED.

1. Please provide the diagnosis this therapy has been prescribed for: _____

ICD-9 Code: _____

2. Select one: **(Only Singulair (montelukast) can be considered for a diagnosis of allergic rhinitis)**

- Singulair (montelukast) 4 mg chew tabs and granule packets; 5 mg chew tabs; and 10 mg oral tabs
 Zyflo CR (zileuton) 600 mg tablets

Drug Strength: ____mg Quantity/30 days: ____ units

For diagnosis of asthma:

3. Has the patient tried and failed zafirlukast, an inhaled β -agonist **OR** a corticosteroid? Yes No

4. List agents tried/failed and any intolerances, side effects, or contraindications below:

For diagnosis of allergic rhinitis:

5. Has the patient tried and failed a nasal steroid **AND** a non-sedating antihistamine? Yes No

6. List all agents tried/failed and any intolerances, side effects, or contraindications below:

Printed Name

Signature

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