pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

LEUKOTRIENE MODIFIERS PRIOR AUTHORIZATION FORM

- **Please submit all requested documentation with this form. Incomplete documentation may delay the processing of this request.**
- Prior authorization guidelines for **Leukotriene Modifiers** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at http://www.dhs.pa.gov/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization.

PRIOR AUTHORIZATION REQUEST INFORMATION		PRESCRIBER INFORMATION	
☐New request ☐Renewal request	total # of pgs: _____	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:	☐Accolate tablet*	☐Singulair tablet*	☐zileuton ER tablet
	☐montelukast granule	☐Singulair chewable*	☐Zyflo tablet*
	☐Singulair granule*	☐zafirlukast tablet	☐Zyflo CR tablet

Strength:	Directions:	Quantity:	Refills:
Diagnosis:		Dx code (required):	

1. Did the Recipient try and fail the preferred Leukotriene Modifier, **montelukast tablet or chewable tablet**?	☐Yes – *Submit all supporting documentation of drug regimen and therapeutic failure.* ☐No
2. Does the Recipient have any contraindications or intolerances to the preferred agent listed in question (1)?	☐Yes – *Submit all supporting documentation of medication name(s) and associated intolerances / contraindications.* ☐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? *Include reason in space below and submit medical record documentation supporting the brand medically necessary request.*

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

Prescriber Signature:	**Date**: