**OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.**
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

# Leukotriene Modifiers Prior Authorization Request Form (Page 1 of 2)

**DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED**

## Member Information (required)

| | | |
|---|---|---|
| Member Name: | | |
| Insurance ID#: | | |
| Date of Birth: | | |
| Street Address: | | |
| City: | State: | Zip: |
| Phone: | | |

## Provider Information (required)

| | | |
|---|---|---|
| Provider Name: | | |
| NPI#: | Specialty: | |
| Office Phone: | | |
| Office Fax: | | |
| Office Street Address: | | |
| City: | State: | Zip: |

## Medication Information (required)

| | |
|---|---|
| Medication Name: | Strength: / Dosage Form: |
| ❑ Check if requesting **brand** | Directions for Use: |
| ❑ Check if request is for **continuation of therapy** | |

## Clinical Information (required)

**Select the diagnosis below:**

❑ Allergic rhinitis [for **Singulair (montelukast)** only]
❑ Asthma
❑ Exercise-induced bronchoconstriction [for **Singulair (montelukast)** only]
❑ Other diagnosis: _____ ICD-10 Code(s): _____

**For allergic rhinitis, select the medications the patient has a failure, contraindication, or intolerance to:**

❑ Allegra, Allegra D
❑ Allegra orally-disintegrating tablet (ODT)
❑ Azelastine 0.1%
❑ Azelastine 0.15% (Astepro)
❑ Beconase AQ
❑ Budesonide
❑ Cetirizine, cetirizine-pseudoephedrine
❑ Claritin
❑ Clarinex, Clarinex ODT
❑ Desloratadine, desloratadine ODT
❑ Dymista
❑ Fexofenadine
❑ Fexofenadine-pseudoephedrine
❑ Flunisolide
❑ Fluticasone (Flonase)
❑ Levocetirizine
❑ Loratadine
❑ Mometasone (Nasonex)
❑ Olopatadine (Patanase)
❑ Omnaris
❑ Qnasl
❑ Triamcinolone (Nasacort)
❑ Veramyst
❑ Xyzal
❑ Zetonna
❑ Zyrtec, Zyrtec-D

**For asthma, select the medications the patient has a failure, contraindication, or intolerance to:**

❑ An anticholinergic bronchodilator (e.g., Atrovent HFA, Spiriva)
❑ An inhaled beta-agonist (e.g., Proventil HFA, Serevent)
❑ An inhaled beta-agonist/corticosteroid combination (e.g., Advair, Symbicort)
❑ An inhaled corticosteroid (e.g., Flovent, Pulmicort Flexhaler, QVAR)
❑ An oral beta-agonist (e.g., albuterol syrup/tablet)
❑ Other oral steroid (e.g., hydrocortisone)
❑ Methylprednisolone
❑ Montelukast
❑ Prednisolone
❑ Prednisone
❑ Zafirlukast

**Other Diagnoses:**

**For atopic dermatitis, select the medications the patient has a failure, contraindication, or intolerance to:**

❑ A topical corticosteroid (e.g., alclometasone, amcinonide, betamethasone, clobetasol, desonide, desoximetasone, diflorasone, fluocinolone, fluocinonide, fluticasone, halcinonide, halobetasol, hydrocortisone, mometasone, prednicarbate, triamcinolone)
❑ An antihistamine (e.g., cetirizine, hydroxyzine)

**For chronic urticaria:**

Does the patient have a history of failure, contraindication, or intolerance to an antihistamine (e.g., cetirizine, desloratadine, fexofenadine, hydroxyzine, levocetirizine, loratadine)? ❑ **Yes** ❑ **No**

**Quantity limit requests:**

What is the quantity requested per DAY? _____

**What is the reason for exceeding the plan limitations?**

❑ Titration or loading dose purposes
❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
❑ Requested strength/dose is not commercially available
❑ Other: _____

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# Leukotriene Modifiers Prior Authorization Request Form (Page 2 of 2)

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

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

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