

**LEUKOTRIENE MODIFIERS
(ACCOLATE[®], SINGULAIR[®], ZYFLO[®])
PREAUTHORIZATION REQUEST
PHYSICIAN FAX FORM**



**BlueCross BlueShield
of Illinois**

ONLY the prescribing physician may complete and fax this form.

Incomplete forms will be returned for additional information. The following documentation is required for preauthorization consideration. For formulary information and to download additional forms, please visit www.bcbsil.com

Patient first name _____ Patient last name _____

Blue Cross ID number _____ Date of birth (MM/DD/YYYY) _____

Patient address _____ Patient phone (_____) _____

Requesting physician _____

Physician specialty _____ Physician UPIN# _____ Physician NPI# _____

Physician signature _____ Date _____

Physician (clinic name) and address _____

Phone (_____) _____ Fax (_____) _____

Patient diagnosis _____

Medication requested (circle one): **ACCOLATE[®]** **SINGULAIR[®]** **ZYFLO[®]**

1. Is the patient currently receiving the requested medication? Yes No
If yes, when was treatment with the requested medication started? _____

2. **If the diagnosis is asthma**, is the patient currently using an orally inhaled corticosteroid? Yes No
If no, does the patient have a history of intolerance, allergy or contraindication to an orally inhaled corticosteroid? Yes No
Is the patient able to effectively use an orally inhaled corticosteroid device? Yes No

3. **If the diagnosis is allergic rhinitis**, is the patient currently using a nasally inhaled corticosteroid? Yes No
If no, does the patient have a history of intolerance, allergy or contraindication to a nasally inhaled corticosteroid? Yes No
Is the patient able to effectively use a nasally inhaled corticosteroid device? Yes No
Is the patient currently taking a non-sedating antihistamine? Yes No

4. **If the diagnosis is exercise-induced asthma**, is the patient able to effectively use a metered dose inhaler (i.e., albuterol)? Yes No

5. Please list all reasons for selecting the requested medication over alternatives (e.g. contraindications, allergies or history of adverse drug reactions to alternatives) _____

PLEASE FAX OR MAIL THIS FORM TO:
Blue Cross and Blue Shield of Illinois
c/o Prime Therapeutics LLC, Clinical Review Department
1020 Discovery Road, No. 100
Eagan, Minnesota 55121

TOLL FREE:
Fax: 877.480.8130 **Phone:** 800.285.9426

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