BlueChoice HealthPlan of South Carolina

Medicaid

CONTAINS CONFIDENTIAL PATIENT INFORMATION

Singulair (montelukast)

Complete form in its entirety and fax to:
Prior Authorization of Benefits (PAB) Center at (866) 807- 6241

1. PATIENT INFORMATION	2. PHYSICIAN INFORMATION
Patient Name: ______________	Prescribing Physician: ______________
Patient ID #: ______________	Physician Address: ______________
Patient DOB: ______________	Physician Phone #: ______________
Date of Rx: ______________	Physician Fax #: ______________
Patient Phone #: ______________	Physician Specialty: ______________
Patient Email Address: ______________	Physician DEA: ______________
	Physician NPI #: ______________
	Physician Email Address: ______________

3. MEDICATION	4. STRENGTH	5. DIRECTIONS	6. QUANTITY PER 30 DAYS
□ Singulair (montelukast)	□ 4mg Chew □ 10mgTablets □ 5mg Chew □ 4mg Packet	______________	Specify: ______________

7. DIAGNOSIS: ______________

8. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY
NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.

□ Yes □ No Is the patient 5 years of age or younger?
□ Yes □ No Is the patient being treated for allergic rhinitis?
□ Yes □ No Is the patient being treated for asthma?
□ Yes □ No Is documentation (chart notes or prescription history of use within the last 3 months) provided for a treatment failure for one or more of the following? (please check all that apply AND submit documentation):
- □ Yes □ No Intranasal steroid (if diagnosis is allergic rhinitis)
- □ Yes □ No Any Non-Sedating Antihistamines (NSA) (if diagnosis is allergic rhinitis)
- □ Yes □ No Inhaled corticosteroid (if diagnosis is asthma)

□ Yes □ No Is the patient using Singulair for prevention of exercise-induced bronchospasm (EIB)?
□ Yes □ No Is the patient 15 years of age or older?

9. PHYSICIAN SIGNATURE

______________________________ ______________________________
Prescriber or Authorized Signature Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

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Medicaid managed care administered by WellPoint Partnership Plan, LLC, an independent company.