LEUKOTRIENE MODIFIERS
(Accolate®, Singulair®, Zyflo®, Zyflo CR™)
PREAUTHORIZATION
PHYSICIAN FAX FORM

The following documentation is REQUIRED for preauthorization. Incomplete forms will be returned for additional information. For formulary information, please visit the Blue Cross and Blue Shield of Nebraska website at ***www.bcbsne.com***

Today's Date: ______________________________

PATIENT INFORMATION

Patient Name (First):	Last:	M.I.:	DOB (mm/dd/yyyy):	Telephone Number:

INSURANCE INFORMATION

BCBS ID Number:	Group Number:

PHYSICIAN/CLINIC INFORMATION

Prescriber Name:	Physician UPIN#:	Physician NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:			
City, State, Zip:		Phone #:	Secure Fax #:	

PREAUTHORIZATION INFORMATION

MEDICATION REQUESTED (check one) ☐ **ACCOLATE®** ☐ **SINGULAIR®** ☐ **ZYFLO®** ☐ **ZYFLO CR™**

1. Patient's diagnosis to be treated with requested medication ______________________________

2. **If the diagnosis is asthma or allergic rhinitis:**
   Is the patient currently prescribed an inhaled nasal or inhaled oral corticosteroid? .... ☐ YES ☐ NO
   If no, does the patient have any contraindications to inhaled nasal or inhaled oral corticosteroids? .... ☐ YES ☐ NO
   Please describe the contraindication ______________________________
   ____

3. **If the diagnosis is exercise induced asthma/bronchoconstriction:**
   Is the patient currently prescribed an inhaled Short Acting Beta Agonist (such as albuterol)? .... ☐ YES ☐ NO
   If no, does the patient have any contraindications to a Short Acting Beta Agonist? .... ☐ YES ☐ NO
   Please describe the contraindication ______________________________
   ____

   Is the patient able to use a metered dose inhaler? .... ☐ YES ☐ NO
   If no, please indicate the reason ______________________________
   ____

4. Please list all other medications the patient is **currently taking** for treatment of this diagnosis.
   ____

5. Please list all medications the patient has **previously tried and failed** for treatment of this diagnosis. (Please specify if the patient has tried brand-named products, generic products or over-the-counter products.)
   ____

6. Please include any additional information that should be considered with this review ______________________________
   ____

Please fax or mail this form to:
Blue Cross and Blue Shield of Nebraska
Pharmacy Department - UM
7261 Mercy Road
Omaha, NE 68180-0001

Toll Free Fax: 877-232-6726
Phone: 877-999-2374

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