

**Community Care of Wake & Johnston Counties
MD Easy™ Form – Leukotriene Modifiers**

This form MUST BE FAXED to the PHARMACY

Practice Information		Patient Information	
Practice Name		Patient Name	
Practice Address		Patient Address	
Practice City, State, Zip		Patient City, State, Zip	
Practice Phone	Practice Fax	Date of Birth	Medicaid ID
Pharmacy Information		Originally Prescribed Leukotriene Modifier	
Pharmacy Name		Drug Name/Strength	
Pharmacy Phone	Pharmacy Fax	Last Filled	Quantity

Leukotriene Modifier Prior Authorization Criteria

Condition-Specific Criteria to use Accolate, Singulair, Zyrflo, or Zyrflo CR:

- Covered with diagnosis of **ASTHMA** if:
 - Patient has documented adverse reaction or contraindication to inhaled corticosteroids, patient has growth suppression due to inhaled corticosteroids, or patient is on medium dose inhaled corticosteroid and needs addition of Leukotriene Receptor Antagonist or 5-Lipoxygenase Inhibitor to achieve control (**step 4 or higher** of the Stepwise Approach for Managing Asthma Long Term – National Asthma Education and Prevention Program)
- Covered with diagnosis of **ALLERGIC RHINITIS** (Singulair only) if:
 - Patient (adult or child) has a documented failure with a 30 day trial of an inhaled nasal steroid spray AND documented failure with a 30 day trial of a non-sedating antihistamine during the last 12 months
 - Patient has documented adverse reaction or contraindication to inhaled nasal steroids AND non-sedating antihistamines
- Covered for prevention of **EXERCISE-INDUCED BRONCHOCONSTRICTION** (EIB) in patients ≥ 15 years of age (Singulair only) if:
 - Patient has a documented failure on a short acting bronchodilator during the last 12 months
 - Patient has documented adverse reaction or contraindication to short acting bronchodilators

PAs can be submitted for patients who meet the above criteria by phoning ACS at 866-246-8505 or by faxing a PA request form (located at www.ncmedicaidbpm.com) to ACS at 866-246-8507. No PA request will be accepted prior to October 28, 2009.

Please select one of the following options and fax to patient's pharmacy

****Attention Pharmacists****

*Please discontinue originally prescribed Leukotriene Modifier listed above and change patient to the approved therapy below.
If the patient does not immediately need this prescription, please keep it on file for the next refill.*

Allergic Rhinitis Treatment Options:			Asthma / EIB Treatment Option:
Loratadine OTC <input type="checkbox"/> 5 mg <input type="checkbox"/> 10 mg <input type="checkbox"/> 5 mg / 5 mL	Cetirizine OTC <input type="checkbox"/> 5 mg <input type="checkbox"/> 10mg <input type="checkbox"/> 1 mg / 1 mL	<input type="checkbox"/> Fluticasone nasal spray 16 gm <input type="checkbox"/> Flunisolide nasal spray 0.025%, 25mL	<input type="checkbox"/> QVAR 40 MCG <input type="checkbox"/> QVAR 80 MCG <input type="checkbox"/> Proventil/Ventolin HFA

Directions: _____

Prescriber Signature: _____

Date: _____

Prescriber Name (please print): _____

DEA/NPI: _____

Note: By signing this document & checking the substitution above, you are consenting to this being a legal prescription & the pharmacy should fill it as such.