

Fax completed form to: 1-866-868-0858
Questions, please call: 1-866-316-6049



Important Information About Prescription Drug Coverage

To: _____ From: _____

Fax: _____ Pages: _____

Re: Pulmicort Respules® (Budesonide): Prior Authorization Request Form: Please respond.

- Please complete the attached Pulmicort Respules® (Budesonide) Prior Authorization Request Form
- To expedite the review process please complete all requested fields.
- Completed forms should be faxed to: 1-866-868-0858. It is not necessary to fax this cover page.

Please note: By signing the attached form you are certifying that the treatment requested is medically necessary. No contraindications are present and precautions have been considered. You will be supervising the patient's treatment. Supporting documentation is available in the patient's record. Signature on this form attests to the fact that the corresponding ICD-9 code has been documented in the patients chart and submitted on a CMS- 1500 form.

Information about this drug

Pulmicort Respules®(Budesonide)
Inhalation solutions are covered under the Medicare Part B DME benefit when used as a supply with a nebulizer in the home. Coverage of inhalation solutions under Part D is limited to certain long-term care facilities. Medicare Part B will cover inhalation solutions when administered at home OR in an assisted living facility, OR an intermediate care facility for the Mentally Retarded (ICF/MR).

You can make an expedited request by indicating this at the top of the attached form. If you request an expedited review, and sign the attached form, you certify that applying the 72 hour standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

Information on the attached form is protected health information and subject to all privacy and security regulations under HIPAA.

Prior Authorization Request Form

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Patient Information

Name _____
Member ID _____
Medicare ID _____
Date of birth _____ Sex: M / F
Address _____
City _____
State _____ ZIP _____
Phone _____
Nursing home resident? YES / NO
Home care patient? YES / NO

Prescriber and Pharmacy Information

Name _____
Specialty _____
DEA _____
NPI _____
Address _____
City _____
State _____ ZIP _____
Phone _____ Fax _____
Pharmacy name _____
NCPDP _____
NPI _____
Phone _____ Fax _____

All items below this line are for Physician Use Only

Information for Requested Drug

Strength: _____ Dosage form: _____ Qty per 30 days: _____ Drug is (circle one): Newly prescribed/Refill
Directions: _____ Diagnosis: _____ ICD-9 Code: _____

Standard Reviews will be completed in under 72 hours. An expedited review is available if you certify that a standard review timeframe will seriously jeopardize the health of your patient. To request an expedited review, simply indicate this at the top of this page.

Pulmicort Respules®(Budesonide) Criteria

- 1 Indicate route of administration
 inhalation via nebulizer
 Other route _____
- 2 Please indicate the patient's diagnosis. Select or specify the correct ICD-9 code. This question must be completed.
 asthma (ICD-9:493)
 other (diagnosis and ICD-9) _____
- 3 Does the patient require nebulized administration due to inability to use metered dose inhalers with spacer/mask and dry powder inhalers?
 Yes No
- 4 Has patient failed to receive a clinically appropriate therapeutic response from maximally efficacious doses of two (2) or more inhaled corticosteroids to treat this condition over a period of 30 or more days for each drug?
 Yes No
- 5 Indicate where the patient resides:
 Long term care resident: Hospital or skilled nursing facility bed who does not have part A coverage, whose part A coverage has run out or whose stay is not covered OR A nursing home that is dually-certified as both a Medicare SNF and a

Medicaid SNF OR A Medicaid-only NF that primarily furnishes skilled care OR A non-participating nursing home (i.e., neither Medicare or Medicaid) that provides primarily skilled care OR An institution which has a distinct part SNF which also primarily furnishes skilled care.

- At home OR An assisted living facility OR An intermediate care facility for the mentally retarded (ICF/MR).
 None of the above; please specify location: _____

Medical justification: (Attach additional page if necessary): _____

Prescriber's signature: _____ Date: _____