

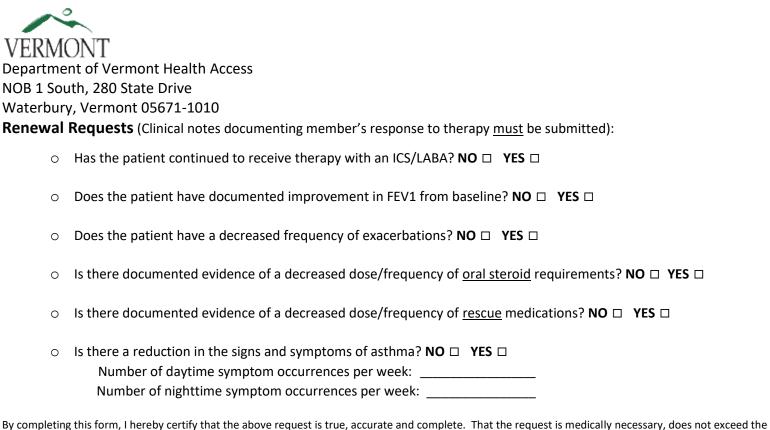
~Cinqair~

Prior Authorization Request Form

In order for members to receive Medicaid coverage for medications that require prior authorization, the prescriber must fax this form to Change Healthcare. Please complete this form in its entirety, and sign and date below. Incomplete requests will be returned for additional information. For questions, please contact the Change Healthcare Helpdesk at 1-844-679-5363.

		Submit red	quest via Fax: 1	-844-679	-5366			
Prescribing physician: Name: NPI: Specialty: Phone#: Fax#: Address: Contact Person at Office:			Beneficiary: Name:					
						Patient's Phone:Pharmacy Name:		Sex:
			Pharmacy NPI:		Pharmacy Fax:			
			Pharmacy Phon	e:	Pharmacy Fax:			
				llowing MUST be completed		ENEFIT requests:		
			HCPCS J-code or other code: Administering Provider/Facility: Name			NDI#		Medicaid ID#
- Carrinin	istering i rovider/i demty. Ivai		ΙΝΙ Ιπ		Wicalcald ID#			
Dose: _				Patient weight (kg):				
0	Is the prescriber an allergist ICS/LABA combination proc Specific Drug:	luct trialed for a		cutive mont	hs: of use:			
0	Does the patient have uncoat least one a week): NO	YES □	Number of daytime s	ymptom occ	almost daily or waking at night with asthma currences per week:			
0	Has the patient had 2 or more exacerbations in the previous year despite use of medium-high dose ICS/LABA: NO \Box YES \Box							
0	Eosinophilic phenotype as o			NO □ YES □				
	Eosinophil Count:	otained:						
0	Has the patient trialed Dup	ixent or Fasenra	a? NO □ YES □ Respo	nse to thera	py:			





By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in your medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.

Prescribers Signature:	Date:

