



Pulmozyme[®] Prior Authorization Request Form

Please fax the completed request form to Mercy Health Plans Pharmacy Department at 314-214-8201 or 800-647-2240. For additional information please call 314-214-8282 or 800-647-2240.

Patient Name: _____ Today's Date: ____/____/____
 Patient Pharmacy ID: _____ Date of Birth: ____/____/____
 (located on bottom right of insurance card)
 Requesting Physician: _____ Specialty: _____
 (Please print)
 Office Contact Person: _____ Phone #: (____)____-____ ext ____
 Office Address: _____
 Medication/dose Requested: _____ Fax #: (____)____-____
 Expected Duration of Therapy: _____ ICD-9: _____

Please circle YES or NO:		
1. Does the patient have a diagnosis of cystic fibrosis ?	YES	NO
<input type="checkbox"/> Is the patient five years of age or older?	YES	NO

Physician's Signature: _____ **Date:** ____/____/____

For Mercy Health Plans use only:	
<input type="checkbox"/> Approved	Length of Approval _____
<input type="checkbox"/> Denied	Reason for Denial _____
Reviewer's Signature: _____	Date Reviewed: ____/____/____
Override Entered in <input type="checkbox"/> Caremark <input type="checkbox"/> CCMS for _____ - _____ by _____	
Office Notified on _____; at _____ am/pm; by _____ spoke to _____	