

**Health New England
Medication Request Form (MRF)
Singulair[®] (montelukast)**

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Contacted:
Physician:
Pharmacy:
Patient:

Prior Authorization

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Approved:
Quantity approved:
PA from and thru date:
PA #
Denied:
Returned:

Instructions:

This form is to be used by participating physicians and pharmacy providers to obtain coverage of Singulair[®]. Please complete this form and fax to MedMetrics Health Partners at (800) 550-9246. If you have any questions regarding this process, please contact MedMetrics clinical call center at (866) 209-1057.

Medication Request Information (please complete each section of this form prior to transmittal):

Patient Information (all required)	Physician Information (all required)
Patient Name:	Physician Name:
	Specialty:
	NPI #:
Patient HNE ID#:	HNE Provider #:
Patient Date of Birth:	DEA #:
Allergies:	Area Code and Telephone #: () -
	Area Code and Fax #: () -

Drug Information

Requested Drug / Strength: Singulair[®]		
Dose, directions and length of treatment (please be specific):	Quantity (per month):	Refills:
Physician signature:	Date:	
Indication (required):		
<input type="checkbox"/> Asthma		
<input type="checkbox"/> Other: _____		