



**Entocort EC**  
(budesonide)

**Express Scripts**  
**Prior Authorization**  
**Phone 800-417-8164**  
**Fax 877-837-5922**

**Please have the information below ready when calling in the authorization.**

Member's Last Name:	Member's First Name:
SCAN ID number:	Date of Birth:
Prescriber's Name:	Contact Person:
Office phone:	Office Fax:

Medication:	Diagnosis:
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<p><b>1. Is the medication prescribed for the treatment of mild to moderate active Crohn's disease involving the ileum and/or the ascending colon OR the maintenance of clinical remission of mild to moderate Crohn's disease involving the ileum and/or the ascending colon for up to 3 months?</b></p>
<p><b>2. Has the patient tried and failed or is the patient intolerant to oral aminosalicylates (i.e., sulfasalazine, balsalazide (Colazal), Pentasa, Asacol, Lialda, Apriso, or mesalamine) or oral prednisone/prednisolone?</b></p>
<p><b>3. Are there any other comments, diagnoses, symptoms, relevant lab values, and/or additional pertinent information that you feel is important to this review?</b></p>

Notice: **Failure to provide all information requested on this form may result in delayed processing or an adverse determination for insufficient information.** Our response time for prescription drug coverage requests is 72 hours. View our formulary and Prior Authorization forms online at <http://www.scanhealthplan.com>.