



**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
VH 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 Crohn's disease involving the ileum and/or ascending colon? If so, please specify which one.</b></p>
<p><b>2. Has the patient tried and failed or is the patient intolerant to oral aminosalicylates (i.e. sulfasalazine, Pentasa, Lialda, or Asacol)? If so, please specify.</b></p>
<p><b>3. Is oral prednisolone/prednisone contraindicated in this patient (i.e. elderly, diabetic, hypertension, history of GI ulcer, etc.) and/or has the patient experienced severe adverse events with prednisolone/prednisone? If so, please specify.</b></p>
<p><b>4. 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>.