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:

1. **Is the medication prescribed for the treatment of mild to moderate active Crohn's disease involving the ileum and/or the ascending colon and 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?**
2. **Has the patient tried and failed or is the patient intolerant to oral aminosalicylates (i.e., sulfasalazine, Pentasa or Asacol) or oral prednisone/prednisolone?**
3. **Are there any other comments, diagnoses, symptoms, relevant lab values, and/or additional pertinent information that you feel is important to this review?**

Notice: **Failure to complete this form in its entirety 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.**