



**Neighborhood Health Plan of Rhode Island
Prior Authorization Form
Entocort® EC and generic budesonide EC**

If approval criteria are met, Neighborhood Health Plan of Rhode Island will authorize coverage of **Entocort EC® or generic budesonide EC**. Failure to fill out this form will result in a rejection of this medication at the pharmacy. Thank you for your assistance.

Please complete the following information:

Member Name: (required)	Member ID Number: (required) <table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table>								
Member Date of Birth: (required) / /	Member Sex: M F (Circle One)								
Prescriber Name: (required)	Contact Person at Office:								
Office Phone number: (required) () -	Office Fax Number: (required) () -								

Directions of use: _____

Quantity _____ **Duration of Treatment** _____

Neighborhood’s criteria for approval of Entocort EC® or generic budesonide EC requires that the patient has been diagnosed with mild to moderate *active* Crohn’s disease involving the ileum and/or ascending colon OR is receiving maintenance treatment for the clinical remission of mild to moderate Crohn’s disease involving the ileum and/or ascending colon for up to 3 months. (note - coverage of maintenance therapy is limited to 3 months unless rationale is included under “Other rationale for use” below)

Please Check all that apply:

- Patient has been diagnosed with mild to moderate active Crohn’s disease involving the ileum and/or ascending colon.
- Patient is receiving maintenance treatment for the clinical remission of mild to moderate active Crohn’s disease involving the ileum and/or ascending colon.
Date treatment initiated _____
- Other rationale for use (please specify) _____

All information provided on this form is accurate as of this date.

Provider Signature: _____ **NPI** _____ **Date:** _____

Completed forms should be faxed to: Customer Service Department (866) 423-0945