

**CONTAINS CONFIDENTIAL PATIENT INFORMATION**  
**Atrovent Nasal® (ipratropium bromide)**  
**Prior Authorization of Benefits (PAB) Form**  
 Complete form in its entirety and fax to:  
**Prior Authorization of Benefits Center at (800) 601- 4829**

**1. PATIENT INFORMATION**

**2. PHYSICIAN INFORMATION**

Patient Name: _____ Patient ID #: _____ Patient DOB: _____ Date of Rx: _____ Patient Phone #: _____ Patient Email Address: _____	Prescribing Physician: _____ Physician Address: _____ Physician Phone #: _____ Physician Fax #: _____ Physician Specialty: _____ Physician DEA: _____ Physician NPI #: _____ Physician Email Address: _____
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**3. MEDICATION**

**4. STRENGTH**

**5. DIRECTIONS**

**6. QUANTITY PER 30 DAYS**

<input type="checkbox"/> Atrovent Nasal (ipratropium bromide) <input type="checkbox"/> Atrovent Inhaler (ipratropium) <input type="checkbox"/> Atrovent Inhalation Solution (ipratropium)	<input type="checkbox"/> 0.03% (QL: 2 bottles/30 days) <input type="checkbox"/> 0.06% (QL: 3 bottles/30 days) <input type="checkbox"/> 17mcg/inh (QL: 3 inhalers/30 days) <input type="checkbox"/> 2.5ml (QL: 6 boxes/30 days)	_____ _____	Specify: _____
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**7. DIAGNOSIS:** \_\_\_\_\_

**8. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY**

**NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.**

A physician letter is required when the quantity limits for the drug requested are exceeded.

The letter submitted should contain: patient's name, identification number, diagnosis, bronchodilator, dosage, and brief explanation as to why greater than maximum allowed dosage is needed

Please attach the physician letter to this request.

**9. PHYSICIAN SIGNATURE**

_____ Prescriber or Authorized Signature	_____ Date
<i>Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.</i>	
Note: Payment is subject to member eligibility. Authorization does not guarantee payment.	
<b>IMPORTANT WARNING:</b> This message is intended for the use of the person or entity to which it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this information is <b>STRICTLY PROHIBITED</b> . If you have received this message by error, please notify us immediately at <b>(800) 338-6180</b> and destroy the related message or return the document to us at 6625 West 78th St. BL0345, Bloomington, MN 55439. You, the recipient, are obligated to maintain it in a safe, secure, and confidential manner. Re-disclosure without appropriate patient consent or as permitted by law is prohibited. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in Federal and State law.	