AmeriHealth

Prior Authorization Form

Singulair®

ONLY COMPLETED REQUESTS WILL BE REVIEWED

Drug Requested: ☐ **Singulair**

Date: _____ Patient ID#: _____ DOB:_____

Patient Name: _____ Provider NPI: _____

Prescribing Physician: _____ Office Contact: _____

Office Fax #: _____ Office Phone: _____

ONLY COMPLETED REQUESTS WILL BE REVIEWED

1. DIAGNOSIS FOR DRUG REQUESTED:

☐ Asthma ☐ Seasonal allergic rhinitis ☐ Prevention of exercise induced bronchoconstriction

☐ Other (specify)_____

2. MEDICATION HISTORY

a. Has the patient tried any prescription nonsedating antihistamines (e.g. fexofenadine (Allegra®), desloratadine (Clarinex®), levocetirizine (Xyzal®))? ☐ Yes ☐ No

b. Has the patient tried any over the counter nonsedating antihistamines (e.g. Loratadine (Claritin®, Alavert®), cetirizine (Zyrtec®))? ☐ Yes ☐ No

c. Has the patient tried any intranasal corticosteroids (e.g. beclomethasone (Vancenase®), budesonide (Rhinocort®), fluticasone (Flonase®), mometasone (Nasonex®), triamcinolone (Nasacort®))? ☐ Yes ☐ No

Please add any other supporting medical information that may be useful in the decision-making process:

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_____

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FAX TO (888) 671-5285. YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL.

Internal use only **Coverage effective date / /**

Document #_____ Processor Initials_____ Date_____

M F Rx coverage Y N STANDARD - SELECT LOB_____

Previous Auth Y N **Approved** **Reviewer Initials**_____ Date_____