



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:

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
Previous Auth				Y	N
			Approved	Reviewer Initials _____	Date _____