Please complete ALL information below and fax your request to 1-888-671-5285

Carbinoxamine, Karbinal® ER, Ryvent™ Coverage Determination Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:	Office Contact:	
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name: Select one of the following: ❑ Request is for **GENERIC** ❑ Request is for **BRAND** (unable to take the generic)	Strength:	Dosage Form:
❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the Type(s) of Coverage Determination Requested:

❑ **Non-Formulary**- Request is for a drug not on the plan's list of covered drugs OR was previously included on the plan's list is being/was removed from this list during the plan year.

❑ **Prior Authorization**- Request is for a drug that requires prior authorization under the plan.

Select the diagnosis below:

❑ Allergic conjunctivitis due to inhalant allergens and food
❑ Anaphylaxis, adjunct after acute manifestations controlled
❑ Dermatographic urticaria (dermatographism)
❑ Hypersensitivity reaction to blood or plasma
❑ Mild, uncomplicated allergic skin manifestations of urticaria and angioedema
❑ Seasonal and perennial allergic rhinitis
❑ Vasomotor rhinitis
❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

Is there documentation that the risk versus benefit has been assessed for this request of a high risk medication (HRM) in an elderly patient? ❑ **Yes** ❑ **No**

Select the medication(s) the patient has a history of trial and failure, or intolerance to:

❑ Azelastine nasal spray
❑ Clarinex syrup
❑ Cyproheptadine
❑ Desloratadine
❑ Levocetirizine
❑ Olopatadine nasal spray
❑ Phenadoz
❑ Promethazine
❑ Promethegan

❑ Other drugs in the same class. Please specify: _____

❑ Other therapeutic equivalent alternatives. Please specify: _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.