



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: <input type="checkbox"/> Request is for <b>GENERIC</b> <input type="checkbox"/> Request is for <b>BRAND</b> (unable to take the generic)	Strength:	Dosage Form:
<input type="checkbox"/> Check if request is for <b>continuation of therapy</b>	Directions for Use:	

Clinical Information (required)	
<b>Select the Type(s) of Coverage Determination Requested:</b>	
<input type="checkbox"/> <b>Non-Formulary</b> - Request is for a drug not on the plan's list of covered drugs OR was previously included on the plan's list and is being/was removed from this list during the plan year.	
<input type="checkbox"/> <b>Prior Authorization</b> - Request is for a drug that requires prior authorization under the plan.	
<b>Select the diagnosis below:</b>	
<input type="checkbox"/> Allergic conjunctivitis due to inhalant allergens and food	
<input type="checkbox"/> Anaphylaxis, adjunct after acute manifestations controlled	
<input type="checkbox"/> Dermatographic urticaria (dermatographism)	
<input type="checkbox"/> Hypersensitivity reaction to blood or plasma	
<input type="checkbox"/> Mild, uncomplicated allergic skin manifestations of urticaria and angioedema	
<input type="checkbox"/> Seasonal and perennial allergic rhinitis	
<input type="checkbox"/> Vasomotor rhinitis	
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____	

<b>Clinical information:</b> Is there documentation that the risk versus benefit has been assessed for this request of a high risk medication (HRM) in an elderly patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
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<b>Select the medication(s) the patient has a history of trial and failure, or intolerance to:</b>
<input type="checkbox"/> Azelastine nasal spray <input type="checkbox"/> Olopatadine nasal spray
<input type="checkbox"/> Clarinex syrup <input type="checkbox"/> Phenadoz
<input type="checkbox"/> Cyproheptadine <input type="checkbox"/> Promethazine
<input type="checkbox"/> Desloratadine <input type="checkbox"/> Promethegan
<input type="checkbox"/> Levocetirizine
<input type="checkbox"/> Other drugs in the same class. Please specify: _____
<input type="checkbox"/> 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.

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