CONTAINS CONFIDENTIAL PATIENT INFORMATION
Non-preferred Non-Sedating Antihistamines (NSAs)
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

Patient Name: _____

Patient ID #: _____

Patient DOB: _____

Date of Rx: _____

Patient Phone #: _____

Patient Email Address: _____

2. PHYSICIAN INFORMATION

Prescribing Physician: _____

Physician Address: _____

Physician Phone #: _____

Physician Fax #: _____

Physician Specialty: _____

Physician DEA: _____

Physician NPI #: _____

Physician Email Address: _____

3. MEDICATION

- □ Allegra/Allegra Suspension
- □ Allegra-D 12 Hour/24 Hour
- □ Clarinex/Clarinex Redi-Tab/ ClarinexSyrup
- □ Clarinex-D 12 Hour/24 Hour
- □ Xyzal/Xyzal Solution
- □ Semprex-D

4. STRENGTH

- □ 30mg ODT
- □ 60mg
- □ 180mg
- □ 30mg/5ml
- □ 60-120mg
- □ 180-240mg
- □ 2.5mg
- □ 5mg
- □ 2.5mg/5ml
- □ 2.5-120mg
- □ 5-240mg
- □ 5mg
- □ 2.5mg/5ml
- □ 8-60mg

5. QTY PER 30 DAYS

- □ 30
- □ 60
- □ 300mL
- □ 900mL
- □ Other: _____

6. DIAGNOSIS: _____

7. 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.

Trial of the preferred prescription generic NSA(s) and each of the Over-The-Counter NSA(s)

DRUG NAME	DOSE	SIG	TRIAL DATE(s)	TRIAL DURATION
1.				
2.				
3.				
4.				

□ Yes □ No Symptoms continued despite treatment with preferred prescription generic NSA(s)

Please describe: _____

_____

NOTE: Documentation must be provided for trial(s) of the preferred prescription generic NSA(s). Documentation includes, but is not limited to, chart notes, prescription claims records, prescription receipts, and laboratory data.

8. PHYSICIAN SIGNATURE

_____ _____

Prescriber or Authorized Signature Date

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.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

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