

# SINGULAIR

## PRIOR AUTHORIZATION REQUEST FORM

Complete ENTIRE form and Fax to: 866-940-7328

Today's Date :

### SECTION A - PATIENT INFORMATION

First Name:	Last Name:	Member ID:
Address:		
City:	State:	Zip:
Phone:	DOB:	Allergies:
Primary Insurance:	Policy #:	Group #:

Is the requested medication **NEW**  or a **CONTINUATION of THERAPY** ? If so, start date: \_\_\_\_\_

Is this patient currently hospitalized?  Yes  No

### SECTION B - PHYSICIAN INFORMATION

First Name:	Last Name:	M.D./D.O.	
Address:	City:	State:	Zip:
Phone:	Fax:	NPI #:	Specialty:

Office Contact Name / Fax Attention to:

### SECTION C - MEDICAL INFORMATION

Medication:	Strength:
Directions for use:	
Diagnosis (Please be specific & provide as much information as possible):	ICD-9 CODE:

- Has the patient been previously treated with an inhaled corticosteroid? \_\_\_\_\_
- Did the patient experience an intolerance/ adverse reactions, or has a documented contraindication, to treatment with an inhaled corticosteroid? \_\_\_\_\_
- Has the patient been previously treated with a second generation antihistamine (e.g. cetirizine, loratadine) and an intranasal corticosteroid (e.g. fluticasone, flunisolide)? \_\_\_\_\_
- Did the patient experience an intolerance/ adverse reactions, or has a documented contraindication, to treatment with a second generation antihistamine and an intranasal corticosteroid? \_\_\_\_\_

#### Other Medications tried

Medications	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Confidentiality Notice:** This transmission contains confidential information belonging to the sender and UnitedHealthcare. This information is intended only for the use of UnitedHealthcare. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action involving the contents of this document is prohibited. If you have received this telecopy in error, please notify the sender immediately.