

**CONTAINS CONFIDENTIAL PATIENT INFORMATION**

**Clarinex (desloratadine)**

**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**

**2. PHYSICIAN INFORMATION**

Patient Name: _____	Prescribing Physician: _____
Patient ID #: _____	Physician Address: _____
Patient DOB: _____	Physician Phone #: _____
Date of Rx: _____	Physician Fax #: _____
Patient Phone #: _____	Physician Specialty: _____
Patient Email Address: _____	Physician DEA: _____
	Physician NPI #: _____
	Physician Email Address: _____

**3. MEDICATION**

**4. STRENGTH**

**5. QTY PER 30 DAYS**

<input type="checkbox"/> Clarinex/Clarinex Redi-Tab/ ClarinexSyrup	<input type="checkbox"/> 2.5mg <input type="checkbox"/> 5mg <input type="checkbox"/> 2.5mg/5ml	_____
<input type="checkbox"/> Clarinex-D 12 Hour/24 Hour	<input type="checkbox"/> 2.5-120mg <input type="checkbox"/> 5-240mg	_____

**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 (levocetirizine) 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

Please describe: \_\_\_\_\_

**NOTE: Documentation must be provided for trial(s) of the preferred prescription generic NSA. 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.

The document(s) accompanying this transmission may contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation.

If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.