BlueCross BlueShield of Louisiana

An independent licensee of the Blue Cross and Blue Shield Association.

P.O. Box 98031 • Baton Rouge, Louisiana • 70898-9031

CONFIDENTIAL
PATIENT INFORMATION

EXPRESS SCRIPTS® Charting the Future of Pharmacy

DRUG AUTHORIZATION FORM
Oral and Nasal Allergy Agents

Phone: 800-842-2015 Fax: 877-837-5922

PATIENT DATA	Last Name	First Name	Policy Number	Date of Birth	Age
REQUESTING PHYSICIAN DATA	Last Name	First Name	Contact Name	Fax Number ( )	

BCBSLA Provider Number	Area of Practice/Specialty	Phone Number ( )

REQUESTED DRUG*

- ☐ Astelin®
- ☐ **Astepro®**
- ☐ Beconase AQ®
- ☐ Clarinex®
- ☐ Clarinex-D®
- ☐ Flonase®
- ☐ Nasarel®
- ☐ Nasonex®
- ☐ **Omnaris®**
- ☐ Patanase®
- ☐ Rhinocort Aqua™
- ☐ Singulair®
- ☐ Veramyst®
- ☐ Xyzal®
- ☐ Other___________________________

INDICATION / DIAGNOSIS

- ☐ Allergic Rhinitis
- ☐ Asthma or Reactive Airway Disease
- ☐ Atopic Dermatitis
- ☐ Chronic Urticaria
- ☐ Eosinophilic Gastroenteritis or Eosinophilic Esophagitis
- ☐ Infant with Acute Respiratory Syncytial Virus (RSV) Bronchiolitis
- ☐ Interstitial Cystitis
- ☐ Other ____

PAST TREATMENT HISTORY (Check ALL that apply)

- ☐ Aspirin
- ☐ Azelastine
- ☐ Cetirizine (prescription only)
- ☐ Cimetidine
- ☐ Clarinex®
- ☐ Clarinex-D®
- ☐ Ditropan® (oxybutynin)
- ☐ Elmiron® (pentosan polysulfate)
- ☐ Fexofenadine (prescription only)
- ☐ Fexofenadine/pseudoephedrine (prescription only)
- ☐ Flunisolide
- ☐ Fluticasone
- ☐ Hydroxyzine
- ☐ Intravesicular therapy (i.e. dimethyl sulfoxide, hyaluronic acid, heparin, Bacillus Calmette-Guerin)
- ☐ Levocetirizine
- ☐ Neurontin® (gabapentin)
- ☐ Nonsteroidal anti-inflammatory drug (NSAID)
- ☐ OTC Allegra® (suspension, ODT)
- ☐ OTC Claritin® (syrup, chewable or reditab)
- ☐ OTC Zyrtec® (syrup or chewable)
- ☐ Procardia® (nifedipine)
- ☐ Pyridium® (phenazopyridine)
- ☐ Topical corticosteroid (prescription only)
- ☐ Topical immunomodulator (i.e. Elidel®, Protopic®)
- ☐ Triamcinolone acetonide nasal spray
- ☐ Tricyclic antidepressant (i.e. amitriptyline, doxepin, imipramine)
- ☐ Xyzal®
- ☐ Other(s):____

OTHER CLINICAL INFORMATION (Check ALL that apply)

- ☐ Yes ☐ No Is the patient currently pregnant?
- ☐ Yes ☐ No Is the patient < 2 years of age?
- ☐ Yes ☐ No Is the patient < 4 years of age?
- ☐ Yes ☐ No Does the patient have a feeding tube (i.e. nasogastric tube or gastric tube)?
- ☐ Yes ☐ No Does the patient have difficulty swallowing tablets or can not swallow tablets?
- ☐ Yes ☐ No Is there clinical evidence or patient history that suggests the step 1 medication will be ineffective or cause an adverse reaction to the patient? ____
____

PHYSICIAN SIGNATURE	**DATE**
______________________________ **Prescribing Physician**	______________________

*Preferred brand drugs (Tier 2) are designated in bold.

Note: On behalf of Blue Cross and Blue Shield of Louisiana, prior authorizations are administered by Express Scripts, Inc., an independent pharmacy benefit management company. Please note that the authorization is not a guarantee of payment. Payment is subject to the member's eligibility, benefits, and pre-existing condition limitations at the time the services are provided. The submitting provider certifies that the information contained herein is true, accurate, and complete and the requested services are medically necessary to the health of the patient.

Incomplete forms will not be processed