CONTAINS CONFIDENTIAL PATIENT INFORMATION
Alomide (lodoxamide tromethamine)
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	4. STRENGTH	5. QUANTITY PER 30 DAYS
□ Alomide (lodoxamide tromethamine)	□ 0.1% Solution (10mL Drop- Tainer)	_____

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.

□ Yes □ No Patient is currently taking the requested medication via a step therapy authorization from another insurance carrier

□ Yes □ No Patient has had a trial of one preferred ophthalmic allergy product (azelastine hydrochloride [generic Optivar], Crolom, Opticrom, Pataday or Patanol)

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

□ Yes □ No Symptoms continued despite treatment with the preferred ophthalmic allergy product.

Please describe: _____

_____

8. For requests for greater than 1 bottle per 30 days, please answer the following:

Specify dose and quantity desired for one month: _____

Who indicates more than 1 bottle per month is required (max allowable 20ml per 30 days with override)?

□ physician □ pharmacist □ member

□ Yes □ No Has the patient received a quantity override in the previous calendar year?

If yes, how many times? _____

Duration of therapy requested:_____; If duration is 6 months to 1 year, physician has submitted a letter with the member's name, identification number, diagnosis, agent needed, dosage and brief explanation as to why greater than the maximum allowed (20ml per 30 days) dosage or quantity is needed for an extended amount of time.

□ Yes □ No Is the quantity requested greater than the maximum quantity (20ml per 30 days)

If yes, please medically justify: _____

CONTINUED ON PAGE 2

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9. 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.