Date _____

Client _____

PRIOR AUTHORIZATION CRITERIA-NSAH: Clarinex-D®

M.D. Last Name: _____ ***M.D. First Name:*** _____

Physician Phone: _____ ***Physician Fax:*** _____

Patient _____ ***ID#*** _____ ***DOB*** _____

****FAILURE TO COMPLETE THE FORM MAY RESULT IN AN AUTOMATIC DENIAL****

1. Has the patient tried and failed a 30-day supply of generic fexofenadine plus pseudoephedrine (12 hour)? Yes No

   a. If Yes, provide dates of trial _____

   b. If No, provide the rationale for non-trial _____

2. Has the patient tried and failed a 30-day supply of any other antihistamines including OTC products? Yes No

   a. If Yes, specify drug(s) and dates of trial _____

   b. If No, proceed to Question #3

3. Physician Signature or name of person providing answers _____

Physician Comments _____

_____

_____

Send or Fax completed form to:
877-329-7279

RESTAT
11900 W. Lake Park Dr.
Milwaukee, WI 53224

www.restat.com

QUESTIONS PLEASE CALL:
877-526-9906