

**FORWARDHEALTH  
PRIOR AUTHORIZATION DRUG ATTACHMENT FOR SINGULAIR®**

**Instructions:** Print or type clearly. Refer to the Prior Authorization Drug Attachment for Singulair® Completion Instructions, F-00204A, for more information.

The only strength of Singulair® for which prior authorization may be requested is Singulair® 10 mg.

**SECTION I — MEMBER INFORMATION**

1. Name — Member (Last, First, Middle Initial)

2. Member Identification Number

3. Date of Birth — Member

**SECTION II — PRESCRIPTION INFORMATION**

4. Drug Name  
Singulair®

5. Drug Strength  
10 mg

6. Date Prescription Written

7. Refills

8. Directions for Use

9. Name — Prescriber

10. National Provider Identifier (NPI) — Prescriber

11. Address — Prescriber (Street, City, State, ZIP+4 Code)

12. Telephone Number — Prescriber

**SECTION III — CLINICAL INFORMATION**

13. Diagnosis Code and Description

14. Has the member tried loratadine and experienced an adverse drug reaction or tried loratadine for at least one week and experienced a treatment failure?

Yes

No

If yes, list the specific details about the adverse drug reaction or the treatment failure and the approximate dates loratadine was taken in the space provided.

15. Has the member tried cetirizine and experienced an adverse drug reaction or tried cetirizine for at least one week and experienced a treatment failure?

Yes

No

If yes, list the specific details about the adverse drug reaction or the treatment failure and the approximate dates cetirizine was taken in the space provided.

16. Has the member tried fluticasone and experienced an adverse drug reaction or tried fluticasone for at least two weeks and experienced a treatment failure?

Yes

No

If yes, list the specific details about the adverse drug reaction or the treatment failure and the approximate dates fluticasone was taken in the space provided.

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DT-PA088-088

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**SECTION III — CLINICAL INFORMATION (Continued)**

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17. Has the member tried flunisolide and experienced an adverse drug reaction or tried flunisolide for at least two weeks and experienced a treatment failure?  Yes  No

If yes, list the specific details about the adverse drug reaction or treatment failure and the approximate dates flunisolide was taken in the space provided.

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18. Has the member taken loratadine or cetirizine in combination with fluticasone or flunisolide for at least two weeks and experienced a treatment failure?  Yes  No

If yes, list the drugs involved, the specific details about the treatment failure, and the approximate dates the drugs were taken in the space provided.

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**SECTION IV — AUTHORIZED SIGNATURE (Include authorization statement or attestation, if needed.)**

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19. SIGNATURE — Prescriber

20. Date Signed

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**SECTION V — ADDITIONAL INFORMATION**

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21. Include any additional information in the space below. Additional diagnostic and clinical information explaining the need for the product requested may be included here.
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