



4. Depending on the diagnosis, please indicate if the patient has been treated with any of the following:

- |   |   |
|---|---|
| <input type="checkbox"/> Accolate<br><input type="checkbox"/> Elidel<br><input type="checkbox"/> Nasal Antihistamine (i.e., azelastine, Astelin, Astepro, Patanase)<br>Please List: _____<br>_____<br><input type="checkbox"/> Nasal Steroid (e.g. Nasonex, Flonase/fluticasone nasal spray, Nasacort AQ/ triamcinolone nasal spray, Nasarel/flunisolide nasal spray, Rhinocort, Beconase, Veramyst, Omnaris)<br>Please List: _____<br>_____<br>_____ | <input type="checkbox"/> Non-sedating or low-sedating antihistamine (i.e. cetirizine (Zyrtec), loratadine (Claritin), Clarinex, Xyzal, fexofenadine (Allegra), or their combination with pseudoephedrine)<br>Please List: _____<br>_____<br><input type="checkbox"/> Protopic<br><input type="checkbox"/> Singulair<br><input type="checkbox"/> Topical Corticosteroids<br>Please list topical corticosteroids tried, including strengths:<br>_____<br>_____<br><input type="checkbox"/> Zafirlukast (generic Accolate) |
|---|---|

5. For the diagnosis of interstitial cystitis only, has the patient tried two alternative therapies for this condition?

- |                              |                             |                              |
|------------------------------|-----------------------------|------------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
|------------------------------|-----------------------------|------------------------------|

If yes, please list other therapies tried: \_\_\_\_\_  
 \_\_\_\_\_

**Are there any other comments, diagnoses, symptoms, and/or any other information the physician feels is important to this review?**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Prescriber Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Office Contact Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Based upon each patient's prescription plan, additional questions may be required to complete the prior authorization process. If you have any questions about the process or required information, please contact our prior authorization team at the number listed on the top of this form.

Prior Authorization of Benefits is not the practice of medicine or a substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for the patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions.

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