

Bravo Health

Coverage Review / Prior Authorization Request Form

Antihistamines/Decongestants

Cyproheptadine, Allegra-D, Clarinex, Xyzal and others



Patient Information		Prescriber Information	
Member Name:		Prescriber Name:	
Bravo ID #		Prescriber Specialty:	
DOB:		Prescriber Address:	
Address:			
		Office Phone#:	
Home Phone:		Office Fax #:	
		Contact Person:	
Diagnosis and Medication Requested			
Medication Requested (dosage, frequency):		Qty:	
Prescribing Diagnosis:	ICD9 Code:	Date Therapy Initiated:	
Clinical Criteria			
1. What condition is the medication being used to treat: <ul style="list-style-type: none">◆ Cold/Flu symptoms◆ Allergic Rhinitis◆ Other, please explain:			
2. What medications has the member tried and failed? Please submit clinical notes supporting documented failures. _____ _____			
<u>*Progress notes or other clinical documentation confirming treatment failure or intolerance to formulary or preferred drugs must be provided (if applicable.)</u>			
Request for Expedited Review			
<input type="checkbox"/> REQUEST FOR EXPEDITED REVIEW [24 HOURS] BY CHECKING THIS BOX AND SIGNING BELOW, I CERTIFY THAT APPLYING THE 72 HOUR STANDARD REVIEW TIME FRAME MAY SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE MEMBER OR THE MEMBER'S ABILITY TO REGAIN MAXIMUM FUNCTION			

Prescriber's Signature:

_____ Date: _____