



Date _____

Client _____

PRIOR AUTHORIZATION QUESTIONNAIRE-SINGULAIR®

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. Diagnosis:
- Asthma (proceed to Question #2)
 - Allergic Rhinitis (proceed to Question #4)
 - Exercise-Induced Bronchoconstriction (EIB) (proceed to Question #6)
 - Other (please specify): _____

ASTHMA

2. Indicate severity of the Asthma:
- Mild Intermittent Mild Persistent Moderate Persistent Severe Persistent
3. Indicate ALL that the patient has tried in the past 12 months (proceed to Question #6):
- Inhaled corticosteroids or oral corticosteroids (Ex. Flovent, prednisone)
 - Beta-agonist (Ex. albuterol inhaler)
 - Xanthine derivative (Ex. theophylline)
 - Inhaled corticosteroid/Long-acting beta agonist (LABA) combination product (Ex. Advair, Symbicort)
 - Mast cell stabilizer (Ex. Cromolyn)

ALLERGIC RHINITIS

4. Is the patient currently using, or has the patient tried/failed a nasal-inhaled steroid? Yes No
- a. If Yes, specify drug and dates of trial _____
- b. If No, provide the rationale for non-trial _____
5. Is the patient currently using, or has the patient tried/failed a nasal or oral antihistamine? Yes No
- a. If Yes, specify drug and dates of trial _____
- b. If No, provide the rationale for non-trial _____

6. 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

QUESTIONS PLEASE CALL:
877-526-9906

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