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Antihistamines — Oral Prior Authorization of Benefits Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION
Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 1-844-512-9004 or Provider Help Desk 1-800-454-3730

1. Patient information	**2. Physician information**
Patient name: _____	Prescribing physician: _____
Patient ID #: _____	Physician address: _____
Patient DOB: _____	Physician phone #: _____
Date of Rx: _____	Physician fax #: _____
Patient phone #: _____	Physician specialty: _____
Patient email address: _____	Physician DEA: _____
	Physician NPI #: _____
	Physician email address: _____

3. Medication	**4. Strength**	**5. Directions**	**6. Quantity per 30 days**
_____	_____	_____	Specify: _____

7. Diagnosis: _____

8. Approval criteria: (Check all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.)

Prior authorization (PA) is required for all non-preferred oral antihistamines.

Patients 21 years of age and older must have three unsuccessful trials with oral antihistamines that do not require PA prior to the approval of a nonpreferred oral antihistamine. Two of the trials must be with cetirizine and loratadine.

Patients 20 years of age and younger must have an unsuccessful trial with cetirizine and loratadine prior to the approval of a nonpreferred oral antihistamine. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

Preferred 1st generation antihistamines (no PA required)

☐ Chlorpheniramine Maleate (OTC)
☐ Cyproheptadine
☐ Diphenhydramine (OTC)
☐ Other preferred as listed on PDL

Nonpreferred 1st generation antihistamines (PA required)

☐ Carbinoxamine Maleate
☐ Clemastine Fumarate
☐ Dexchlorpheniramine maleate

Preferred 2nd generation OTC antihistamines (no PA required)

☐ Loratadine Tab (OTC)
☐ Cetirizine Tab (OTC)
☐ Loratadine Syrup (OTC)
☐ Cetirizine Syrup (OTC)

Nonpreferred 2nd generation antihistamines (PA required)

☐ Clarinex/Clarinex D
☐ Levocetirizine
☐ Desloratadine
☐ Xyzal

Document antihistamine treatment failure(s) including drug names, strength, exact date ranges and failure reasons:

_____

_____

Medical or contraindication reason to override trial requirements:_____

Reason for use of nonpreferred drug requiring prior approval:_____

Attach lab results and other documentation as necessary.

9. Physician signature

_____ _____

Prescriber or authorized signature Date

Prior authorization of benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations and exclusions. The submitting provider certifies that the information provided is true, accurate and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.