



## Non-Sedating Antihistamines Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:
Medication Information (required)					
Medication Name:			Strength:	Dosage Form:	
<input type="checkbox"/> Check if requesting <b>brand</b>			Directions for Use:		
<input type="checkbox"/> Check if request is for <b>continuation of therapy</b>					
Clinical Information (required)					
<b>Select the diagnosis below:</b> <input type="checkbox"/> Chronic idiopathic urticaria <input type="checkbox"/> Perennial allergic rhinitis <input type="checkbox"/> Seasonal allergic rhinitis <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____					
<b>Medication history:</b> Has the patient tried and failed a 14-day trial of one of the following: cetirizine, cetirizine & pseudoephedrine, fexofenadine, fexofenadine & pseudoephedrine, loratadine, or loratadine & pseudoephedrine? <input type="checkbox"/> Yes <input type="checkbox"/> No					
<b>Clinical information:</b> Does the patient have a documented difficulty in swallowing diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No					
<b>Quantity limit requests:</b> What is the quantity requested per DAY? _____ <b>What is the reason for exceeding the plan limitations?</b> <input type="checkbox"/> Titration or loading dose purposes <input type="checkbox"/> Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime) <input type="checkbox"/> Requested strength/dose is not commercially available <input type="checkbox"/> Other: _____					

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

Please note: This request may be denied unless all required information is received.  
For urgent or expedited requests please call 1-855-401-4262.  
This form may be used for non-urgent requests and faxed to 1-844-403-1029.

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