

ANTI-HISTAMINES, MINIMALLY SEDATING PRIOR AUTHORIZATION FORM

- Prior authorization guidelines and quantity limits may be found in the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapters – **Antihistamines, Minimally Sedating** and **Quantity Limits/Daily Dose Limits**, accessible on the Department's Pharmacy Services website at <http://www.dhs.pa.gov/provider/pharmacyservices/index.htm>.

PRIOR AUTHORIZATION INFORMATION			PRESCRIBER INFORMATION		
<input type="checkbox"/> New request	<input type="checkbox"/> Additional info	# of pages in request: _____	Prescriber name: _____		
<input type="checkbox"/> Renewal request	PA# _____				
Name of office contact: _____			Specialty: _____		
Contact's phone number: _____			State license #: _____		
LTC facility contact/phone: _____			NPI: _____	MA Provider ID#: _____	
RECIPIENT INFORMATION			Street address: _____		
Recipient Name: _____			Suite #: _____	City/state/zip: _____	
Recipient ID#: _____	DOB: _____	Phone: _____	Fax: _____		

CLINICAL INFORMATION

Non-preferred medication requested:	<input type="checkbox"/> All Day Allergy OTC (cetirizine) chewable	<input type="checkbox"/> desloratadine ODT	
	<input type="checkbox"/> All Day Allergy-D OTC (cetirizine/PSE) tab	<input type="checkbox"/> fexofenadine OTC tablet	
	<input type="checkbox"/> Aller-Ease OTC (fexofenadine) tablet	<input type="checkbox"/> fexofenadine suspension	
	<input type="checkbox"/> cetirizine OTC chewable	<input type="checkbox"/> fexofenadine-D OTC tablet	
	<input type="checkbox"/> cetirizine-D OTC tablet	<input type="checkbox"/> levocetirizine tablet	
	<input type="checkbox"/> Clarinex tablet	<input type="checkbox"/> levocetirizine solution	
	<input type="checkbox"/> Clarinex-D tablet	<input type="checkbox"/> Semprex-D capsule	
	<input type="checkbox"/> Clarinex syrup	<input type="checkbox"/> Xyzal tablet	
	<input type="checkbox"/> desloratadine tablet	<input type="checkbox"/> Xyzal syrup	
	Strength: _____	Dose/directions: _____	Quantity: _____
Diagnosis (<u>submit documentation</u>): _____		Dx codes (<u>required</u>): _____	
1. Does the Recipient have a history of trial and failure, contraindication, or intolerance of the preferred Minimally Sedating Antihistamines? <i>Check all that apply.</i>			<u>Submit documentation of all medications tried and failed or of contraindications/intolerances</u>
<input type="checkbox"/> cetirizine OTC tablet	<input type="checkbox"/> loratadine OTC ODT or tablet		
<input type="checkbox"/> cetirizine Rx or OTC liquid	<input type="checkbox"/> loratadine-D 12-hr or 24-hr OTC tab		
<input type="checkbox"/> Alavert OTC ODT	<input type="checkbox"/> loratadine OTC liquid		

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature: _____	Date: _____
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