Prior Authorization Request Form – Non-sedating Antihistamines

Instructions:

This form is to be used by participating providers to request coverage for non-sedating antihistamines requiring prior authorization. Please fill out this form COMPLETELY, including signature, and fax to MedMetrics Health Partners at 1-800-918-7542. Allow 24 hours to process request. Please call MedMetrics PA Line (available 24 hours a day) at 1-800-918-7550 for more urgent requests.

MedMetrics Health Partners - Prior Authorization Services
P. O. Box 2586, Worcester, MA 01606

Phone: 1-800-918-7550
Fax: 1-800-918-7542

A non-sedating antihistamine step therapy program has been developed to encourage the use of first-line therapies before second or third-line therapies are used for the same indication. If approved, quantity limits apply.

First-line therapies:	**Second-line therapies:**	**Third-line therapies:**
loratadine/Alavert tablets and syrup	fexofenadine/Allegra (OTC) tablets/suspension/ODT	Clarinex tablets/syrup/Reditabs
loratadine/Alavert-D tablets	fexofenadine-D/Allegra-D	Clarinex-D tablets
loratadine reditabs		levocetirizine tablets
cetirizine tablets (OTC)		Xyzal solution
cetirizine chewables (OTC)		
cetirizine-D tablets (OTC)		
cetirizine syrup (OTC)		

Please PRINT and complete ALL of the following boxes:

1. Member's FULL Name:	2. Member's NHP ID Number:	3. Member's DOB: (mm/dd/yy)

4. Prescriber FULL Name & Specialty:	5. Contact Person at Office:

Prescriber Fax Number & Telephone Number: Fax: (   ) Tel: (   )
Mailing Address:

7. Requested Drug (please specify):____

8. Dose, Frequency, and Duration of Requested Drug:	9. Is Member Pregnant or Breast-feeding? ☐ Yes ☐ No

10. Does the member have a documented swallowing disorder or an inability to swallow tablets? ☐ Yes ☐ No
If Yes, please explain: ____

11. Has the member previously tried the following?

Drug Name (please check all that apply)	**Response (please check all that apply)**		
☐ loratadine (Claritin/Alavert) tablets or reditabs	☐ side-effect	☐ non-response	☐ allergy
☐ loratadine (Claritin/Alavert) syrup	☐ side-effect	☐ non-response	☐ allergy
☐ loratadine-D (loratadine/pseudoephedrine) tablets	☐ side-effect	☐ non-response	☐ allergy
☐ cetirizine (Zyrtec) tablets or chew tabs	☐ side-effect	☐ non-response	☐ allergy
☐ cetirizine-D (cetirizine/pseudoephedrine) tablets	☐ side-effect	☐ non-response	☐ allergy
☐ cetirizine (Zyrtec) syrup	☐ side-effect	☐ non-response	☐ allergy
☐ fexofenadine (Allegra) tablets	☐ side-effect	☐ non-response	☐ allergy
☐ fexofenadine (Allegra) suspension	☐ side-effect	☐ non-response	☐ allergy
☐ fexofenadine/pseudoephedrine (Allegra) tablets	☐ side-effect	☐ non-response	☐ allergy

12. Prescriber comments:

Signature

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

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Prescriber's signature Date