

## Iowa Department of Human Services



## Request for Prior Authorization ANTIHISTAMINES-ORAL

FAX Completed Form To 1 (877) 733-3195 Provider Help Desk 1 (844) 236-1464

(PLEASE PRINT – ACCURACY IS IMPORTANT)

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IA Medicaid Member ID #	Patient name	DOB						
Patient address								
Provider NPI Prescriber name			Phone					
Prescriber address			Fax					
Pharmacy name Address			Phone					
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.								
Pharmacy NPI Pharmacy fax NDC								
	Filalillacy lax							
Prior authorization 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 prior authorization, prior to the approval of a non-preferred 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 non-preferred 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)  Non-Preferred 1st Generation Antihistamines (PA								
Preferred 1st Generation Antihistamines (no PA required) required)  Non- Preference Non- Prefe			d 1st Generat	ion Ant	<u>ihistam</u>	ines (F	<u>PA</u>	
<ul> <li>☐ Chlorpheniramine Maleate (OTC)</li> <li>☐ Cyproheptadine</li> <li>☐ Diphenhydramine (OTC)</li> <li>☐ Other preferred as listed on PDL</li> </ul>		<ul><li>☐ Carbinoxamine Maleate</li><li>☐ Clemastine Fumarate</li><li>☐ Dexchlorpheniramine maleate</li></ul>						
<u>Preferred 2<sup>nd</sup> Generation OTC Antihistamines (no PA required)</u> <u>Non-Preferred 2<sup>nd</sup> Generation Antihistamines (PA required)</u>								
Loratadine Tab (OTC) Loratadine Syrup (OTC)	Cetirizine Tab (OTC) Cetirizine Syrup (OTC)	Clarinex/C	-	Levocetirizine Xyzal				
Strength 	Dosage Instructions	Quantity	Days Suppl	y				
Diagnosis:								
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 Non-Preferred drug requiring prior approval:								
Attach lab results and other documentation as necessary.								
Prescriber signature (Must match prescriber listed above.)			Date of submission					

**IMPORTANT NOTE:** In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.