

NON-SEDATING ANTIHISTAMINES

(Xyzal, Allegra, Clarinex)

Patient name: _____ Medicaid ID #: _____

Prescriber Name: _____ Prescriber NPI#: _____ Contact person: _____

Prescriber Phone#: _____ Extension/Option: _____ Fax#: _____

Pharmacy: _____ Pharmacy Phone#: _____ Pharmacy Fax #: _____

Requested Medication: _____ Strength: _____ Frequency/Day: _____

All information to be legible, complete and correct or form will be returned

FAX DOCUMENTATION FROM PROGRESS

NOTES TO 855-828-4992 note the new fax number

CRITERIA:

DOCUMENTATION stating when and how OTC loratadine and cetirizine preparations have failed.

INFORMATION:

Non-sedating antihistamines limited to 30 doses/30 days.

AUTHORIZATION:

1 year

RE-AUTHORIZATION:

Updated letter of medical necessity

9/15/10