EXPRESS SCRIPTS®

Prior Authorization Form
Antihistamines Step Therapy

This form is based on Express Scripts standard criteria and may not be applicable to all patients; certain plans and situations may require additional information beyond what is specifically requested.
Additional forms available: www.express-scripts.com/pa

Fax completed form to **1-877-329-3760**
If this an **URGENT** request, please call 1-800-753-2851

Patient Information

Patient First Name: _____

Patient Last Name: _____

Patient ID#: _____

Patient DOB: _____

Patient Phone #: _____

Prescriber Information

Prescriber Name: _____

Prescriber DEA/NPI **(required)**: _____

Prescriber Phone #: _____

Prescriber Fax #: _____

Prescriber Address:_____

State: _____ Zip Code: _____

Primary Diagnosis: _____ ICD Code: _____

Please indicate which drug and strength is being requested:

- ☐ Allegra 30mg Tablet
- ☐ Allegra 30mg/5ml Suspension
- ☐ Allegra 60mg Tablet
- ☐ Allegra 60mg Capsule
- ☐ Allegra 180mg Capsule
- ☐ Allegra ODT 30mg
- ☐ Allegra 12-Hour Tablet
- ☐ Allegra-D 12-Hour Tablet
- ☐ Allegra-D 24-Hour Tablet
- ☐ Clarinex 5mg
- ☐ Clarinex 0.5mg/ml Syrup
- ☐ Clarinex RediTabs 2.5mg Orally Disintegrating Tablet
- ☐ Clarinex RediTabs 5mg Orally Disintegrating Tablet
- ☐ Clarinex-D 12 Hour
- ☐ Clarinex-D 24 Hour
- ☐ Xyzal 5mg
- ☐ Xyzal 2.5mg/5ml Solution
- ☐ Zyrtec 5mg Tablet
- ☐ Zyrtec 5mg Chewable Tablet
- ☐ Zyrtec 10mg Chewable Tablet
- ☐ Zyrtec 10mg Liquid Gel Capsule
- ☐ Zyrtec 1mg/ml Syrup
- ☐ Zyrtec-D 12 Hour 5mg-120mg ER
- ☐ Other: _____

Directions for use (i.e. QD, BID, PRN & Qty):_____

Please complete the clinical assessment:		
1. Is the patient currently taking the requested medication? If yes, for how long? _____	☐ Yes	☐ No
2. Is the patient taking samples or paying 100% out of pocket for the medication being requested?	☐ Yes	☐ No
3. Was the patient on the requested drug on a previous occasion?	☐ Yes	☐ No

4. Has the patient tried any of the following antihistamines for their current condition? Please indicate which antihistamine(s) patient has tried: ☐ Cetirizine syrup or chewable tablets (brand or generic) ☐ OTC cetirizine/cetirizine pseudoephedrine (brand or generic) ☐ OTC fexofenadine (brand or generic) ☐ OTC fexofenadine-pseudoephedrine (brand or generic) ☐ OTC loratadine/loratadine-pseudoephedrine (brand or generic) ☐ Prescription cetirizine (brand or generic) ☐ Prescription fexofenadine (generic) ☐ Prescription fexofenadine/pseudoephedrine (generic) ☐ Prescription levocetirizine (generic) ☐ Other: _____ If patient has not tried any of the above antihistamines, please explain: _____ _____ _____	☐ Yes	☐ No
5. Does the patient have difficulty swallowing OR is the patient unable to swallow (e.g. pediatric patients)?	☐ Yes	☐ No

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

_____

_____

_____

_____

Prescriber Signature: _____Date: _____

Office Contact Name: _____ Phone Number: _____

Based upon each patient's prescription plan, additional questions may be required to complete the prior authorization process. If you have any questions about the process or required information, please contact our prior authorization team at the number listed on the top of this form.

Prior Authorization of Benefits is not the practice of medicine or a substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for the patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions.