pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

ANTIHISTAMINES, MINIMALLY SEDATING PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Antihistamines, Minimally Sedating** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at http://www.dhs.pa.gov/provider/pharmacyservices/index.htm.

PRIOR AUTHORIZATION INFORMATION		PRESCRIBER INFORMATION	
☐New request ☐Renewal request	total # of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
BENEFICIARY INFORMATION		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Non-preferred medication requested:

☐cetirizine chewable
☐cetirizine-D tablet
☐Clarinex syrup
☐Clarinex tablet
☐Clarinex-D tablet
☐desloratadine ODT
☐desloratadine tablet
☐fexofenadine suspension
☐fexofenadine tablet
☐fexofenadine-PSE tablet
☐levocetirizine solution
☐levocetirizine tablet
☐Semprex-D capsule
☐_____

Strength:	Dose/directions:	Quantity:	Refills:
Diagnosis *(submit documentation)*:		Dx codes (*required*):	

1. Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the preferred Minimally Sedating Antihistamines? *Check all that apply.*

☐cetirizine tablet
☐cetirizine solution/syrup
☐loratadine ODT or tablet
☐loratadine solution/syrup
☐loratadine-D 12-hr or 24-hr tablet

☐Yes
☐No

Submit documentation of medication regimens tried and treatment response, contraindications, and/or intolerances.

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

Prescriber Signature:	**Date**: