



ANTI-HISTAMINE PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this
Prior authorization, call
866-705-5391

SD Medicaid requires that patients receiving anti-histamines must use **Loratadine*** as first line.

- **Loratadine OTC and cetirizine may be prescribed WITHOUT prior authorization. Loratadine and cetirizine are covered by Medicaid when prescribed by a physician.**
- **Prior authorization is NOT required for patients < 13 years of age.**
- **Patients must use loratadine and cetirizine for a minimum of 14 days for the trial to be considered a failure. Patient preference does not constitute failure.**
- **Patients are encouraged to try and fail generic loratadine and cetirizine prior to receiving a leukotriene modifier or intranasal steroid to treat allergic rhinitis.**

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	RECIPIENT MEDICAID ID NUMBER:
Recipient Date of birth: / /	

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:	PHYSICIAN DEA NUMBER:
CITY:	PHONE: ()
	FAX: ()

Part III: TO BE COMPLETED BY PHYSICIAN:

REQUESTED DRUG (PLEASE CHECK): <input type="checkbox"/> Allegra <input type="checkbox"/> Allegra-D <input type="checkbox"/> Claritin Rx <input type="checkbox"/> Clarinex <input type="checkbox"/> Clarinex -D <input type="checkbox"/> Claritin-D Rx <input type="checkbox"/> Zyrtec <input type="checkbox"/> Zyrtec-D <input type="checkbox"/> Fexofenadine <input type="checkbox"/> Xyzal	Requested Dosage: (must be completed)
	Diagnosis for this request:

Qualifications for coverage:

<input type="checkbox"/> Failed loratadine	Was trial for at least 14 days? <input type="checkbox"/> YES <input type="checkbox"/> NO	Dose:
<input type="checkbox"/> Failed cetirizine		Frequency:
Adverse Reaction (attach FDA Medwatch form) to loratadine or cetirizine or contraindicated: (provide description below)		

Physician Signature:

Date:

Part IV: PHARMACY INFORMATION

PHARMACY NAME:	SD MEDICAID PROVIDER NUMBER:
Phone: ():	FAX: ()
Drug:	NDC#:

Part V: FOR OFFICIAL USE ONLY

Date: / /	Initials: _____
Approved - Effective dates of PA: From: / /	To: / /
Denied: (Reasons)	