



**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:**

<b>REQUESTED DRUG (PLEASE CHECK):</b> <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	<b>Requested Dosage:</b> (must be completed)
	<b>Diagnosis for this request:</b>

**Qualifications for coverage:**

<input type="checkbox"/> Failed loratadine <input type="checkbox"/> Failed cetirizine	Was trial for at least 14 days? <input type="checkbox"/> YES <input type="checkbox"/> NO	Dose:
		Frequency:

Adverse Reaction (attach FDA Medwatch form) to loratadine or cetirizine or contraindicated: (provide description below)

Physician Signature:	Date:
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**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)	