MedStar Medicare Choice

MedStar Medicare Choice
Pharmacy Services
Phone: 855-266-0712
Fax: 855-862-6517

ANTIHISTAMINES
Prior Authorization Request
Carbinoxamine, Clemastine, Cyproheptadine, Diphenhydramine, Hydroxyzine, and Promethazine

□ Standard Request (72 hours) □ Expedited Request (24 hours)	If you or your prescriber believe that waiting 72 hours for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can request an expedited decision. For expedited requests you will receive a decision within 24 hours. You cannot request an expedited coverage determination if you are requesting reimbursement for a drug you already received.

Demographics

Patient Information		Prescriber Information	
Patient Name:		Prescriber Name:	
DOB:	Age:	NPI#:	Specialty:
Health Plan ID#:		Phone:	Fax:
Pharmacy Name:	Pharmacy Phone:	Office Contact:	Direct Phone # or Ext:

Medication Information

Drug Requested:	Strength:	Directions:
Quantity Dispensed:	Day Supply:	□ Generic □ Brand Necessary

Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.

□ New medication □ Continuation of therapy	Start Date:	If this is continuation of therapy, please provide CHART DOCUMENTATION indicating the member showed improvement while on therapy.

Clinical Information

Criteria applies to member age 65 years or older. For member less than 65 years, criteria does not apply.

Diagnosis and previous medication trials:

- □ Allergic rhinitis, allergic conditions, or urticaria
  - Levocetirizine
- □ Nausea or vomiting
  - Ondansetron
- □ Insomnia
  - Lorazepam
  - Trazodone
  - Ramelteon
  - Silenor
- □ Anxiety (prior trial of two therapies required)
  - SSRI _____ _____
  - SNRI _____ _____
  - Other _____ _____
- □ Other _____

Date Diagnosed:_____

Please provide any additional information which should be considered in the space below: