



Date _____

Client _____

PRIOR AUTH CRITERIA - NON-SEDATING ANTIHISTAMINES - (ALLERGY)

M.D. Last Name: _____	M.D. First Name: _____
Physician Phone: _____	Physician Fax: _____
Patient: _____ ID# _____	DOB _____

TO ENSURE PROMPT PROCESSING PLEASE COMPLETE ALL OF THE QUESTIONS.

1. Please circle which agent is being requested:

STEP B
<ul style="list-style-type: none"> • ALLEGRA-D • CLARINEX • CLARINEX-D

0

STEP C
<ul style="list-style-type: none"> • XYZAL • ALLEGRA ODT • ALLEGRA SUSPENSION

Strength requested: _____

Dosage requested: _____

***Please note that if member is beginning therapy with a Non-Sedating Antihistamine, the member's benefit will only cover generic Fexofenadine, unless the member has already tried and failed generic Fexofenadine.**

****Please Note that Step C drugs will not be approved unless all Step B drugs have been tried and failed**

2. Attach chart notes of member's failure on Fexofenadine

Nature of Failure _____

3. Attach chart notes of member's failure on Clarinex

Nature of Failure _____

4. Does the patient have difficulty swallowing? _____

5. Please attach chart notes confirming dysphasia

6. Is the patient pregnant? YES NO

Physician Signature or name of person providing answers _____

Physician Comments _____

Send or Fax completed form to:
877-329-7279

RESTAT
P.O. BOX 758
WEST BEND, WI 53095

QUESTIONS PLEASE CALL:
877-526-9906

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