AmeriHealth Caritas Iowa

AmeriHealth Caritas Iowa
Request for Prior Authorization

Antihistamines-Oral

Form applies to IA Health Link and ***hawk-i*** plans.

Please print – accuracy is important.

Fax completed form to 1-855-825-2714. Provider Help Desk: 1-855-328-1612.

AmeriHealth Caritas Iowa member ID #:		Patient name:	
Patient address:			DOB:
Provider NPI:	Prescriber name:		Phone:
Prescriber address:			Fax:
Pharmacy name:			
Address:			Phone:
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.			
Pharmacy NPI:		Pharmacy fax:	NDC:

Prior authorization is required for all non-preferred oral antihistamines. Patients 21 years of age and older must have three unsuccessful trials with oral antihistamines that do not require prior authorization, prior to the approval of a non-preferred oral antihistamine. Two of the trials must be with cetirizine and loratadine. Patients 20 years of age and younger must have an unsuccessful trial with cetirizine and loratadine prior to the approval of a non-preferred oral antihistamine. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

Please note: AmeriHealth Caritas Iowa uses Iowa Medicaid Enterprise criteria. For complete criteria, please consult www.iowamedicaidpdl.com/pa_criteria.

Preferred 1st Generation Antihistamines (no PA required)	Non- Preferred 1st Generation Antihistamines (PA required)
☐ Chlorpheniramine Maleate (OTC)	☐ Carbinoxamine Maleate
☐ Diphenhydramine (OTC)	☐ Clemastine Fumarate
☐ Other preferred as listed on PDL	☐ Cyproheptadine
	☐ Dexchlorpheniramine Maleate

Preferred 2nd Generation OTC Antihistamines (no PA required)	Non-Preferred 2nd Generation Antihistamines (PA required)
☐ Loratadine Tab (OTC)	☐ Clarinex/Clarinex D
☐ Loratadine Syrup (OTC)	☐ Desloratadine
☐ Cetirizine Tab (OTC)	☐ Levocetirizine
☐ Cetirizine Syrup (OTC)	☐ Xyzal

Strength: Dosage Instructions: Quantity: Days Supply:

Diagnosis:

Document antihistamine treatment failure(s) including drug names, strength, exact date ranges and failure reasons:

Medical or contraindication reason to override trial requirements:

Reason for use of Non-Preferred drug requiring prior approval:

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Attach lab results and other documentation as necessary.

By signing this document, I attest that the information contained herein is true and accurate to the best of my knowledge and belief. By submitting this form, I acknowledge that I am submitting a request for authorization of health care services, and I agree to abide by and adhere to established federal and Iowa fraud, waste and abuse (FWA) rules and regulations and to remain in compliance with AmeriHealth Caritas Iowa's Program Integrity rules. I further attest that any claim I submit is subject to investigations, review or audit as determined by AmeriHealth Caritas Iowa. I further acknowledge that an authorization is not a guarantee of payment.	
Prescriber signature: (Must match prescriber listed above.)	Date of submission:

Important note: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.

Check www.amerihealthcaritasia.com/Provider to confirm your version of this form.