Premier Health Plan

Premier Health Plan
Pharmacy Services
Phone: 866-822-2714
Fax: 855-862-6518

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:

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