iowa total care | Iowa Health Link Iowa HHS | Hawki Iowa HHS

Fax Completed Form To
1.833.404.2392
Prescriber Help Desk
1.833.587.2012
Online
covermymeds.com/main/prior-authorization-forms/

Request for Prior Authorization
ANTIHISTAMINES-ORAL

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
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.

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

Non- Preferred 1st Generation Antihistamines (PA required)
- ☐ Carbinoxamine Maleate
- ☐ Clemastine Fumarate

Preferred 2nd Generation OTC Antihistamines (no PA required)
- ☐ Loratadine Tab (OTC)
- ☐ Loratadine Syrup (OTC)
- ☐ Cetirizine Tab (OTC)
- ☐ Cetirizine Syrup (OTC)

Non-Preferred 2nd Generation Antihistamines (PA required)
- ☐ Clarinex/Clarinex D
- ☐ Desloratadine
- ☐ Levocetirizine

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: _____

Attach lab results and other documentation as necessary.

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 Health and Human Services, that the member continues to be eligible for Medicaid.*

(Rev. 7/25)