Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
P.O. Box 2586, Worcester, MA 01613-2586
Fax: (877) 208-7428 **Phone:** (800) 745-7318

Print Clear

Antihistamine Agents
Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the requesting provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

Additional information about these agents, including PA requirements and preferred products, can be found within the MassHealth Drug List at **www.mass.gov/druglist**.

Member information

Last name _____ First name _____ MI _____

MassHealth member ID # _____ Date of birth _____

Gender (Check one.) ☐ F ☐ M Member's place of residence ☐ home ☐ nursing facility

Medication information

Medication requested (Check one or all that apply.)

Intranasal Antihistamines

☐ azelastine 0.15% nasal spray
☐ olopatadine nasal spray

Single Oral Antihistamines

☐ carbinoxamine 6 mg tablet
☐ desloratadine orally disintegrating tablet (ODT)
☐ desloratadine tablet
☐ dexchlorpheniramine solution
☐ Karbinal ER (carbinoxamine extended-release)
☐ levocetirizine solution

Combination Oral Antihistamines

☐ Clarinex-D (desloratadine/pseudoephedrine)

Dose and frequency of medication requested _____

Indication (Check all that apply.)

☐ Allergic Rhinitis
☐ Non-allergic Rhinitis
☐ Urticaria
☐ Other _____

Please list all other medications currently prescribed for the member for this indication.

_____

Section I. Please complete for desloratadine ODT and levocetirizine solution requests. Please also complete Section II for these medications.

Does the member have a swallowing disorder or condition affecting swallowing ability?

☐ Yes. Please describe. _____

☐ No. Please describe clinical rationale for not using oral tablet formulation. _____

_____

Section II. Please complete for Clarinex-D, desloratadine ODT, and levocetirizine solution.

Has the member had a trial with an intranasal corticosteroid and two second-generation antihistamines (e.g., cetirizine, levocetirizine, loratadine)?

For requests for combination antihistamines, please include information about trials with second-generation antihistamines in combination with pseudoephedrine (e.g., cetirizine/pseudoephedrine, loratadine/pseudoephedrine).

☐ Yes. Please list the drug names, dates/duration of trials, and outcomes below.*

Drug name _____ Dates/duration of use _____

Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other

Briefly describe details of adverse reaction, inadequate response, or other.

_____

Drug name _____ Dates/duration of use _____

Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other

Briefly describe details of adverse reaction, inadequate response, or other.

_____

Drug name _____ Dates/duration of use _____

Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other

Briefly describe details of adverse reaction, inadequate response, or other.

_____

☐ No. Please describe why intranasal corticosteroids and second-generation antihistamines are not appropriate for this member. _____

Section III. Please complete for azelastine 0.15% nasal spray and olopatadine nasal spray requests.

1. Has the member had a trial with an intranasal corticosteroid?

   ☐ Yes. Please list the drug name, dates/duration of trials, and outcomes below.*

   Drug name _____ Dates/duration of use _____

   Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other

   Briefly describe details of adverse reaction, inadequate response, or other.

   _____

   ☐ No. Please describe why intranasal corticosteroids are not appropriate for this member.

   _____

2. Has the member had a trial with azelastine 137 mcg nasal spray?

   ☐ Yes. Please list the dates/duration of trials and outcomes below.*

   Dates/duration of use _____

   Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other

   Briefly describe details of adverse reaction, inadequate response, or other.

   _____

   ☐ No. Please describe why azelastine 137 mcg nasal spray is not appropriate for this member.

   _____

3. For requests for any agent at a quantity > 1 inhaler per month, please document an inadequate response to the manufacturer's recommended dosing.

   _____

   _____

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Section IV. Please complete for carbinoxamine 6 mg tablet and Karbinal ER requests.

1. Has the member had a trial with an intranasal corticosteroid and two non-selective antihistamines?
   ☐ Yes. Please list the drug names, dates/duration of trials, and outcomes below.*
   Drug name _____ Dates/duration of use _____
   Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other
   Briefly describe details of adverse reaction, inadequate response, or other.
   _____
   Drug name _____ Dates/duration of use _____
   Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other
   Briefly describe details of adverse reaction, inadequate response, or other.
   _____
   Drug name _____ Dates/duration of use _____
   Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other
   Briefly describe details of adverse reaction, inadequate response, or other.
   _____
   ☐ No. Please describe why intranasal corticosteroids and non-selective antihistamines are not appropriate for this member. _____
2. For carbinoxamine 6 mg tablet requests, has the member had a trial with carbinoxamine 4 mg tablet?
   ☐ Yes. Please list the dates/duration of trials and outcomes below.*
   Dates/duration of use _____
   Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other
   Briefly describe details of adverse reaction, inadequate response, or other.
   _____
   ☐ No. Please describe why carbinoxamine 4 mg tablet is not appropriate for this member.
   _____
3. For Karbinal ER requests, has the member had a trial with carbinoxamine immediate-release solution?
   ☐ Yes. Please list the dates/duration of trials and outcomes below.*
   Dates/duration of use _____
   Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other
   Briefly describe details of adverse reaction, inadequate response, or other.
   _____
   ☐ No. Please describe why carbinoxamine immediate-release solution is not appropriate for this member.
   _____

**Please attach a letter documenting additional trials as necessary.*

Section V. Please complete for dexchlorpheniramine solution requests.

Has the member had a trial with two antihistamine solutions that do not require prior authorization?
☐ Yes. Please list the drug names, dates/duration of trials, and outcomes below.*
Drug name _____ Dates/duration of use _____
Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other
Briefly describe details of adverse reaction, inadequate response, or other.
_____
Drug name _____ Dates/duration of use _____
Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other
Briefly describe details of adverse reaction, inadequate response, or other.
_____
☐ No. Please explain why not.
_____

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Section VI. Please complete for desloratadine tablet requests.

Has the member had a trial loratadine, cetirizine, or levocetirizine?
☐ Yes. Please list the drug names, dates/duration of trials, and outcomes below.*
Drug name _____ Dates/duration of use _____
Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other
Briefly describe details of adverse reaction, inadequate response, or other.

_____

☐ No. Please describe why loratadine, cetirizine, or levocetirizine are not appropriate for this member.

_____

Section VII. Please complete for all requests for non-preferred drug products if one or more preferred drug products have been designated for this class of drugs.

If one or more preferred drug products have been designated for this class of drugs, and if you are requesting PA for a non-preferred drug product, please provide medical necessity for prescribing the non-preferred drug product rather than the preferred drug product.

_____

_____

Prescriber information

Last name* _____ First name* _____ MI _____
NPI* _____ Individual MH Provider ID _____
DEA No. _____ Office Contact Name _____
Address _____ City _____ State _____ Zip _____
E-mail address _____
Telephone No.* _____ Fax No.* _____
** Required*

Prescribing provider's attestation, signature, and date

I certify under the pains and penalties of perjury that I am the prescribing provider identified in the Prescriber information section of this form. Any attached statement on my letterhead has been reviewed and signed by me. I certify that the medical necessity information (per 130 CMR 450.204) on this form is true, accurate, and complete, to the best of my knowledge. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

Prescribing provider's signature (Signature and date stamps, or the signature of anyone other than the provider, are not acceptable.)

Signature required_____

Printed name of prescribing provider _____ Date _____