



Prior Authorization Criteria for Non-Sedating Antihistamines (please select)

- | | |
|--|--|
| <input type="checkbox"/> Allegra | <input type="checkbox"/> Clarinex |
| <input type="checkbox"/> Allegra-D | <input type="checkbox"/> Clarinex-RediTabs |
| <input type="checkbox"/> Claritin-D 12 hr. | <input type="checkbox"/> Xyzal |

Patient Name: _____ DOB: _____

Doctor: _____ Diagnosis: _____

Please circle responses and return to Welborn Health Plans:

1. Does the patient have the diagnosis of Allergic Rhinitis? If yes, go to **3**. If no, go to **2**.
2. Does the patient have the diagnosis of chronic idiopathic urticaria? If yes, go to **5**.
If no, Deny.
3. Has the patient tried & failed a one-month trial of OTC loratadine or loratadine/pseudoephedrine? If yes, go to **4**, If no, Deny.
4. Has the patient tried & failed a one-month trial of Nasal Steroids [Beconase (AQ), Flonase, Nasacort (AQ), Nasalide, Nasarel, Nasonex, Rhinocort (AQ), Vancenase(AQ)]?
If yes, Approve. If no, Deny.
5. Has the patient tried & failed a one-month trial of OTC loratadine?
If yes, Approve. If no, Deny.

Comments:

Sent in by: _____ Phone: _____ Fax: _____

Fax information to our Pre-Certification Dept. at 716-541-6344. For questions call: 812-426-6600