



Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
 P.O. Box 2586, Worcester, MA 01613-2586
Fax: 1-877-208-7428 **Phone:** 1-800-745-7318

Oral/Intranasal 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
 azelastine 137 mcg nasal spray > 1 inhaler/month

Single Oral Antihistamines

- carbinoxamine desloratadine tablet
 Clarinex (desloratadine syrup) Karbinal ER (carbinoxamine extended-release)
 desloratadine orally disintegrating tablet (ODT) levocetirizine solution

Combination Oral Antihistamines

- Clarinex-D (desloratadine/pseudoephedrine) Semprex-D (acrivastine/pseudoephedrine)

Dose and frequency of medication requested _____

Indication

- Allergic Rhinitis Urticaria
 Non-allergic Rhinitis Other _____

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

Section I. Please complete for Clarinex syrup, 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 syrup, Clarinex-D, desloratadine ODT, desloratadine tablets, levocetirizine solution, and Semprex-D requests.

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. _____

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

Section III. Please complete for azelastine 137 mcg nasal spray > 1 inhaler/month, 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. For azelastine 0.15% nasal spray and olopatadine nasal spray, 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 the diagnosis of allergic rhinitis, has the member had a trial with two second-generation antihistamines (e.g., cetirizine, levocetirizine, loratadine)?

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 describe why second-generation antihistamines are not appropriate for this member.

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

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

Section IV. Please complete for carbinoxamine 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 Karbinal ER requests, has the member had a trial with carbinoxamine immediate-release?

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 is not appropriate for this member.

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

Section V. 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 _____