State of Maine Department of Health & Human Services
MaineCare/MEDEL Prior Authorization Form
NON SEDATING ANTIHISTAMINES

Phone: 1-888-445-0497 **ONE Drug Per Form ONLY – Use Black or Blue Ink** Fax: 1-888-879-6938

Member ID #: |__|__|__|__|__|__|__|__|__|__| (NOT MEDICARE NUMBER) Patient Name: _____ DOB: _____

Patient Address:_____

Provider DEA: |__|__|__|__|__|__|__|__|__| Provider NPI: __|__|__|__|__|__|__|__|__|__|

Provider Name:_____ Phone:_____

Provider Address:_____ Fax:_____

Pharmacy Name:_____Rx Address:_____Rx phone:_____

Provider must fill all information above. It must be legible, correct and complete or form will be returned.

(Pharmacy use only): NPI: __|__|__|__|__|__|__|__|__|__| NABP: |__|__|__|__|__|__|__| NDC: |__|__|__|__|__|__|__|__|__|__|__|

Preferred products required: OTC Loratadine products, Cetirizine. For a complete list of other preferred products, please refer to the OTC list available at www.mainecarepdl.org

Drugs (Step Order)	Strength	Dosage Instructions	Quantity	Days Supply (34 retail / 90 mail order)	Circle Refills
❑ CLARINEX® (5)	_____	_____	_____	_____	1 2 3 4 5
❑ ZYRTEC® (5)	_____	_____	_____	_____	1 2 3 4 5
❑ ALLEGRA® (8)	_____	_____	_____	_____	1 2 3 4 5
❑ OTHER	_____	_____	_____	_____	1 2 3 4 5

Indications Required:

❑ Allergies with Asthma

❑ Seasonal allergic rhinitis (MUST supply initial evaluation documentation Allergy diagnosis)

❑ Chronic idiopathic urticaria

❑ Perennial allergies (MUST provide evidence supporting allergy including skin/ serum testing or allergy specialist note)

❑ Other (describe) _____

Medical Necessity Documentation Required

❑ Failed on OTC Alavert/generic loratadine (describe) _____

❑ Failed on step order therapy. _____

❑ Other _____

Pursuant to the MaineCare Benefits Manual, Chapter I, Section 1.16, The Department regards adequate clinical records as essential for the delivery of quality care, such comprehensive records are key documents for post payment review. Your authorization certifies that the above request is medically necessary, meets the MaineCare criteria for prior authorization, does not exceed the medical needs of the member and is supported in your medical records.

Provider Signature: _____ Date of Submission: _____
***MUST MATCH PROVIDER LISTED ABOVE**