



Kansas Medical Assistance Program
 P O Box 3571
 Topeka, KS 66601-3571
 Provider 1-800-933-6593
 Beneficiary 1-800-766-9012

Prior Authorization for Non-Preferred Non-Sedating Antihistamines

Preferred	Non-Preferred, Prior Authorization Required
Claritin® (loratadine) Claritin 24-hr Allergy® (loratadine) Claritin® Syrup (loratadine) Zyrtec® (cetirizine) Zyrtec® Syrup (cetirizine)	Allegra® (fexofenadine) Allegra® ODT (fexofenadine) Clarinex® (desloratadine) Claritin Hives Relief® (loratadine) Claritin RediTabs® (loratadine) Xyzal® (levocetirizine) The following drugs are covered for KBH only: Allegra-D® (fexofenadine/pseudoephedrine) Allegra-D24® (fexofenadine/pseudoephedrine) Clarinex-D 12-hour® (desloratadine/pseudoephedrine) Clarinex-D 24-hour® (desloratadine/pseudoephedrine)

Beneficiary Information

Name: _____
 Medicaid ID #: _____ Date of Birth: _____

Pharmacy Information

Name: _____ Medicaid ID #: _____
 NPI #: _____ Phone #: _____ Fax #: _____
 Requested Drug: _____ NDC: _____

Prescriber Information

Name: _____ Medicaid ID #: _____
 NPI #: _____ Phone #: _____ Fax #: _____

Please check the appropriate box and provide the required information to receive the requested non-preferred drug.

- Patient has a medical intolerance to preferred drug.** Please provide the name of the preferred drug and clinical symptoms of intolerance experienced by the patient: _____
- Patient has had an inadequate response to preferred drug.** Name of preferred agent patient tried: _____
- An appropriate formulation or indication is not available as a preferred drug.** Please specify which formulation or indication is needed and information supporting the need: _____

Prescriber's Signature: _____ **Date:** _____

**The completed form should be faxed to the HP Prior Authorization Unit at 1-800-913-2229.
 This form will be returned unprocessed if it is not completed in its entirety.**