APPROVED PA Criteria

Initial Approval: July 11, 2018

CRITERIA FOR PRIOR AUTHORIZATION

Carbinoxamine Products - Step Therapy

PROVIDER GROUP: Pharmacy

MANUAL GUIDELINES: All dosage forms of the following medications will require prior authorization.
Carbinoxamine (Arbinoxa®, Karbinal™ ER, RyVent™)

CRITERIA FOR INITIAL APPROVAL: (must meet all of the following)

- Patient must have experienced an inadequate response to a trial of two or more oral and/or intranasal second-generation histamine-1 antagonists for at least 10 days in the past 60 days OR have a documented intolerance or contraindication to two or more oral and/or intranasal second-generation histimine-1 antagonists.
    - Prescriber must provide documentation of all previous medication trials. Documentation must include the medication name(s), trial date(s) and outcome(s) of the trial (i.e. inadequate response, intolerance or contraindication).

CRITERIA FOR RENEWAL:

- Prescriber must attest that the patient has received clinical benefit from continuous treatment with the requested medication.

LENGTH OF APPROVAL: 12 months

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DRUG UTILIZATION REVIEW COMMITTEE CHAIR	PHARMACY PROGRAM MANAGER DIVISION OF HEALTH CARE FINANCE KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT
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DATE	**DATE**