Catamaran Prior Authorization Department
Phone: 866-235-3062
Fax: 866-391-7222

Prescriber Information

Last Name:	**First Name**
DEA/NPI:	**Specialty:**
Phone - -	**Fax** - -

Member Information

Last Name:	**First Name**
Member ID Number	**DOB:** - -

Medication Information:

Drug Name and Strength:	Quantity and Dosing:
Diagnosis:	Duration:

Clarinex, Clarinex-D, Desloratadine ODT
Prior Authorization Criteria

You must answer ALL of the following questions that apply to patient		
1. Have three of the following non-sedating antihistamines been tried and shown to have an inadequate response in the patient? **(If yes, please circle)** A. cetirizine or cetirizine-D B. loratadine or loratadine-D C. fexofenadine or fexofenadine-D D. levocetirizine	Y	N
2. Does the patient have a documented serious adverse event to 3 of the following non-sedating antihistamines? **(If yes, please circle)** A. cetirizine or cetirizine-D B. loratadine or loratadine-D C. fexofenadine or fexofenadine-D D. levocetirizine	Y	N

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Xyzal Solution
Prior Authorization Criteria

You must answer ALL of the following questions that apply to patient		
1. Have two of the following non-sedating antihistamines been tried and shown to have an inadequate response in the patient? **(If yes, please circle)** A. cetirizine or cetirizine-D B. loratadine or loratadine-D C. fexofenadine or fexofenadine-D	Y	N
2. Does the patient have a documented serious adverse event to 2 of the following non-sedating antihistamines? **(If yes, please circle)** A. cetirizine or cetirizine-D B. loratadine or loratadine-D C. fexofenadine or fexofenadine-D	Y	N
3. Has the patient had an inadequate response to levocetirizine?	Y	N
4. Does the patient have a documented serious adverse event levocetirizine?	Y	N
5. Is the patient unable to swallow tablets?	Y	N

Comments: _____

Information given on this form is accurate as of this date.

_____ _____

Prescriber or Authorized Signature **Date**

_____

Authorized Medical Staff – Name/Title

Attention Healthcare Provider: If you would like to discuss this request with a medical professional, please contact the Prior Authorization Department at 866-235-3062.

I understand that Catamaran's use or disclosure of individually identifiable health information, whether furnished by me or obtained by another source such as medical providers, shall be in accordance with federal privacy regulations under HIPAA (Health Insurance Portability and Accountability Act of 1996).