

Prior-Authorization / Prescription Exception Form

Non-Sedating Antihistamines

Please complete and fax form to (706) 549-8004

ALLEGRA®, ALLEGRA-D®, ZYRRTEC®, AND ZYRTEC-D®

Strength: _____ Dosage: _____ Frequency per day: _____

This form must be signed by ordering physician and must be legible before review. Additional information may be requested. Exceptions will be made for dependent children under the age of 16.

Patient Information:

First Name _____ Middle Initial _____ Last _____

Address _____

City _____ State _____ Zip _____

Phone (____) _____ Patient Date of Birth _____

Sex _____ Member ID _____

Physician Information:

Prescribing MD: _____

Address _____

City _____ State _____ Zip _____

Phone (____) _____ Fax(____) _____

Has patient used Claritin OTC or other Loratadine products? Yes or No

If YES to past use of OTC - please answer the following:

How long did patient try the (OTC) Loratadine product? _____

Please explain patient's failure or intolerance to (OTC) Loratadine product(s)? _____

Physician Signature: _____ Date _____

**Please Note: HPS Preferred Non-Sedatings include the following:
Alavert, Alavert D, and all OTC loratadine products.**