

Network Health

Non-Sedating Antihistamines Prior Authorization Request

Medication Request Form (MRF)
FAX TO: (877) 501-1059
 c/o MedImpact Healthcare Systems, Inc.
 Attn: Prior Authorization Department
 10680 Trenea Street, Suite 500, San Diego, CA 92131 - Phone: 1-800-788-2949

**Allegra, Allegra-D, Clarinex,
 Clarinex-D, Semprex-D, Xyzal,
 Zyrtec RX, Zyrtec-D RX**

Instructions:

This form is to be used by participating providers to obtain coverage for the drugs listed above, which require prior authorization. Please complete this form and fax it to MedImpact Healthcare Systems, Inc. at (877) 501-1059. If you have any questions regarding this process, please contact MedImpact's Customer Service at (800) 788-2949.

***** ONLY COMPLETED FORMS CAN BE PROCESSED *****

Member/Provider Information:

Member's Name:	Prescriber's Name:
Member's Network Health ID#:	Prescriber's Specialty:
Member's DOB (mm-dd-yy):	DEA # (Required): _____ NPI #: _____
Pharmacy used by Member:	Prescriber's Telephone Number/ Contact Name:
Pharmacy (Area Code) Telephone Number:	Prescriber's (Area Code) Fax Number:

Clinical Information:

<p>Requested Drug: (Note: OTC products containing cetirizine or loratadine do not require prior authorization) <input type="checkbox"/>Cetirizine RX <input type="checkbox"/>Cetirizine-D RX <input type="checkbox"/>Clarinex <input type="checkbox"/>Clarinex-D <input type="checkbox"/>Fexofenadine <input type="checkbox"/>Fexofenadine-D <input type="checkbox"/>Semprex-D <input type="checkbox"/>Xyzal</p> <hr/> <p><input type="checkbox"/> Allegra Brand Name <input type="checkbox"/> Allegra-D Brand Name <input type="checkbox"/>Zyrtec RX Brand Name <input type="checkbox"/>Zyrtec-D RX Brand Name</p>
Dose and Quantity Requested:
Documentation of Medical Necessity (please check all that apply):
<p>Our guidelines for approval require a trial with the 2 generic OTC agents containing loratadine and cetirizine.</p> <p>1. Please indicate if the patient has had previous trials with generic agents or if the agent is contraindicated (check all that apply, the reason for discontinuation or contraindication):</p> <p style="text-align: center;">Reason for discontinuation or contraindication:</p> <p><input type="checkbox"/> cetirizine _____</p> <p><input type="checkbox"/> cetirizine/pseudoephedrine _____</p> <p><input type="checkbox"/> loratadine _____</p> <p><input type="checkbox"/> loratadine/pseudoephedrine _____</p> <p>2. For BRAND NAME Requests: Justification why generic cannot be used. _____</p> <p>_____</p>

Request for expedited review (72 hours): By checking this box, I certify that applying the standard review time frame may seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function.

SIGNATURE

I CERTIFY THAT THE INFORMATION PROVIDED IS ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE, AND I UNDERSTAND THAT ANY FALSIFICATION, OMISSION, OR CONCEALMENT OF MATERIAL FACT MAY SUBJECT ME TO CIVIL OR CRIMINAL LIABILITY.

Prescriber's Signature (STAMP NOT ACCEPTED)

Date

DO NOT WRITE IN SHADED AREAS FOR INTERNAL USE ONLY
Contacted:
Provider:
Pharmacy:
Patient:

DO NOT WRITE IN SHADED AREAS FOR INTERNAL USE ONLY
Approved:
Denied:
Returned:
PA #