ConnectiCare, Inc. & Affiliates

Pharmacy Pre-authorization Form: Non-Sedating Antihistamines

Note: USE THIS FORM ONLY when seeking pre-authorization for coverage of prescriptions for NON-SEDATING ANTIHISTAMINES. ZYRTEC OTC and CLARITIN OTC are the preferred antihistamine choices for ConnectiCare members, and do not require pre-authorization, though a prescription is required for coverage.

Date:______________________________

Member Name:________________________

Member ID Number:____________________

Member Age:__________________________

Physician Name:____________________________

Physician Specialty:__________________________

Physician Address:___________________________

Physician Telephone:_________________________

Physician Fax/E-mail:________________________

Medication requested (check one):

☐ Clarinex/Clarinex-D ☐ Xyzal

1. Has this patient filled prescriptions for **Claritin/Alavert (Loratadine) AND Zyrtec (Cetirizine) AND Allegra (Fexofenadine)** in the past 2 years, and received coverage for them under their ConnectiCare plan? If there is NO RECORD of claims payment, office notes (within the past 2 years) documenting the trial and outcome MUST BE SUBMITTED FOR REVIEW.	☐ Yes	☐ No
2. Patient's Diagnosis:____ ICD9/ICD10 code(s)*_______________________________________ ****ICD9/ICD 10 codes are required to process all requests.****		

For ConnectiCare Use Only:

Date reviewed:____________________________________

Approved/denied (circle one) by: ______________________ Approval expiration date:__________________

Comments:____

____

____

ConnectiCare Pharmacy Services: FAX — 1-800-249-1367, or e-mail — pharmacy@connecticare.com
To speak to a Medical Director or Pharmacist regarding a pre-authorization decision, call 1-800-828-3407.

*This is confidential information. If you receive this form in error, please notify Provider Services immediately at 1-800-828-3407.
The information in this document does not apply to ConnectiCare VIP Medicare plan members.*