SCRIPTGUIDERX REQUEST FOR PRIOR AUTHORIZATION
STEP THERAPY ANTIHISTAMINES

Prescribing Physician:

Name:______________________________
First Last

Direct Phone #: (_ _ _) ________________

Fax #: (_ _ _) ______________________

Physician specialty: ________________

Patient:

Name:____
First Last

ID#: ____

Phone #: ____________________**Group:**__________

Birth Date: _ _ - _ _ - _ _ _ _ **Sex:** ☐ **Female** ☐ **Male**

Name and title of person completing form (please print): ______________________________________

Drug name: **Strength:** **Administration Schedule:** **Length of Therapy:** **Quantity Requested:**

a)____

Has patient been on this drug and, if yes, for how long at this dosage? _______________________________

Patient's diagnosis requiring the use of this medication: ____

1. Previous history of a medical condition, allergies or other pertinent medical information that necessitates the use of this medication:

____

2. Has the patient been seen by any other provider for this condition? ☐ **Yes** ☐ **No**
If so, what was the prescriber's specialty? ____

3. Previous non-prior authorized and prior authorized medications tried and failed for this condition:

Name of medication	Reason for failure	Date:
___________________________	____________________________________	_ _/ _ _/ _ _ _ _
___________________________	____________________________________	_ _/ _ _/ _ _ _ _
___________________________	____________________________________	_ _/ _ _/ _ _ _ _

4. Pertinent laboratory test or procedure: (if applicable)

Procedure:	Findings:	Date:
___________________________	____________________________________	_ _/ _ _/ _ _ _ _
___________________________	____________________________________	_ _/ _ _/ _ _ _ _
___________________________	____________________________________	_ _/ _ _/ _ _ _ _

** **Antihistamines - please note if any of the following first line agents have been tried such as :**

Claritin OTC (loratadine), Alavert (loratadine), Zyrtec OTC (cetirizine)

***** Please include chart notes if these have been tried.**

Fax Request to: ScriptGuideRX @ 313-264-0985

Date Received: Date Completed:	Decision (all authorizations are pending valid eligibility):

15400 E. Jefferson Avenue ♦ Grosse Pointe Park ♦ MI ♦ 48230 ♦ 313-499-3223 ext 207
www.scriptguiderx.com