



Prior Authorization Approval Criteria

Non-Sedating Antihistamines - Medicaid

Generic Name: fexofenadine, desloratadine, levocetirizine; fexofenadine-PSE, desloratadine-PSE

Brand Name: Allegra, Clarinex, Xyzal; Allegra-D, Clarinex-D

Medication Class: Antihistamine; Antihistamine-decongestant

FDA Approved Uses: Allergic Rhinitis and Chronic Idiopathic Urticaria

Available Dosage Forms: Allegra: 30mg ODT, 30mg 12-hr tabs, 60mg 12-hr tabs, 180mg 24-hr tabs, 30mg/5ml suspension
Allegra-D: 60mg/120mg 12-hr tabs, 180/240mg 24-hr tabs
Clarinex: 2.5mg reditab, 5mg tabs, 0.5mg/ml syrup
Clarinex-D: 2.5/120mg 12-hr tabs, 5/240 24-hr tabs
Xyzal: 5mg tabs, 0.5mg/ml solution

Duration of Therapy: Indefinite, allergy season

Criteria for Use: *(bullet points below are all inclusive unless otherwise noted)*

- Patient has clinically documented allergic rhinitis or chronic idiopathic urticaria
- Patient must have tried and failed or was intolerant to OTC loratadine and OTC cetirizine
- If diagnosis is allergic rhinitis: in addition to above, patient must have tried and failed or was intolerant to at least 1 formulary nasal steroid.

Contraindications:

- Known hypersensitivity to any agent.

Not Approved if:

- The patient does not meet the above stated criteria
- The patient has any contraindications to the use of the agent.

Note: Prescription Zyrtec and prescription Claritin are not covered, as these are available OTC.

P&T Approval: _____ Date: _____