Commercial/Healthcare Exchange PA Criteria

Effective: September 2005

Prior Authorization: Brand Antihistamines

Products Affected: Clarinex, Clarinex-D, RyClora, Ryvent

Medication Description: Antihistamines are a class of agents that block histamine release from histamine-1 receptors and are mostly used to treat allergies or cold and flu symptoms, although some first-generation antihistamines may also be used for other conditions.

Covered Uses:
Clarinex is indicated for the relief of chronic idiopathic urticaria and nasal and non-nasal symptoms of perennial allergic rhinitis in patients 6 months of age and older. In addition, Clarinex is indicated to treat nasal and non-nasal symptoms of seasonal allergic rhinitis in patients 2 years of age and older.

Clarinex-D is indicated for relief of nasal and non-nasal symptoms of seasonal allergic rhinitis, including nasal congestion, in adults and adolescents 12 years of age and older.

RyClora is for the treatment of perennial and seasonal allergic rhinitis; vasomotor rhinitis; allergic conjunctivitis; mild, uncomplicated allergic skin manifestations of urticaria and angioedema; amelioration of allergic reactions to blood or plasma; dermatographism; adjunctive therapy for the management of anaphylactic reactions.

Ryvent is indicated for the symptomatic treatment of seasonal and perennial allergic rhinitis; vasomotor rhinitis; allergic conjunctivitis caused by inhalant allergens and foods; mild, uncomplicated allergic skin manifestations of urticaria and angioedema; dermatographism; as therapy for anaphylactic reactions adjunctive to epinephrine and other standard measures after the acute manifestations have been controlled; amelioration of the severity of allergic reactions to blood or plasma.

Exclusion Criteria: N/A

Required Medical Information:
1. Diagnosis
2. Previous medications tried/failed

Age Restrictions: N/A

Prescriber Restrictions: N/A

Coverage Duration: 12 months

Other Criteria:
Note: The following criteria apply to patients aged 2 years and older. Patients less than 2 years of age are not subject to prior authorization.

Clarinex and Clarinex-D are covered only if the following prior authorization criteria are met:

A. Intolerance to, or treatment failure of a two-week trial to all of the following within the last 2 years:
   a. loratadine (Claritin, Alavert, or other brands)
   b. Zyrtec (cetirizine)
   c. Allegra (fexofenadine)
   d. levocetirizine (Xyzal)

In addition to the above, **RyClora and Ryvent** are covered only if the following prior authorization criteria are met:

A. Intolerance to, or treatment failure of a two-week trial to Clarinex (desloratadine).

References:

1. Clarinex [package insert]. Kenilworth, NJ. Schering Corporation: Clinical Pharmacology Online
2. RyClora package insert. Hazlet, NJ. Carwin Pharmaceutical Associates, LLC

Policy Revision history

Rev #	Type of Change	Summary of Change	Sections Affected	Date
1	New Policy	New Policy	All	September 2005
2	Policy Update	Moved to updated template CCI Revision Record: 6/07, 12/07, 12/09, 3/10, 9/10, 5/11, 12/11, 9/15, 11/16, 5/17, 11/18	All	2/4/2020