Louisiana Medicaid
Dexchlorpheniramine (Ryclora™)

The *Louisiana Uniform Prescription Drug Prior Authorization Form* should be utilized to request clinical authorization for dexchlorpheniramine (Ryclora™).

Additional Point-of-Sale edits may apply.

By submitting the authorization request, the prescriber attests to the conditions available HERE.

Approval Criteria for Initiation of Therapy

- The recipient is less than 21 years of age on the date of the request; **AND**
- The prescriber **states on the request** that the recipient has **ONE** of the following approved indications for the medication:
    - Perennial and seasonal allergic rhinitis; **OR**
    - Vasomotor rhinitis; **OR**
    - Allergic conjunctivitis due to inhalant allergens and foods; **OR**
    - Mild, uncomplicated allergic skin manifestations of urticaria and angioedema; **OR**
    - Amelioration of allergic reactions to blood or plasma; **OR**
    - Dermographism; **OR**
    - As therapy for anaphylactic reactions adjunctive to epinephrine and other standard measures after the acute manifestations have been controlled; **AND**
- The recipient has tried and failed at least **TWO** oral antihistamines for at least 30 days of therapy within the last 6 months [Dates and medications must be **stated on the request**]; **AND**
- The prescriber **states on the request** that the recipient is unable to swallow tablets and/or capsules due to clinical conditions; **AND**
- The recipient is not taking any other medications in tablets and/or capsule form; **AND**
- The recipient is not currently taking any other oral antihistamine medications; **AND**
- The recipient does not have a contraindication to treatments as listed in the package insert.

Approval Criteria for Continuation of Therapy

- The recipient is less than 21 years of age on the date of the request; **AND**
- The prescriber **states on the request** that the recipient is established on the medication with evidence of a positive response to therapy; **AND**
- The recipient is not taking any other medications in tablets and/or capsule form; **AND**
- The recipient is not currently taking any other oral antihistamine medications; **AND**
- The recipient does not have a contraindication to treatments as listed in the package insert.

Duration of approval for initiation and continuation of therapy: 6 months (or up to the recipient's 21st birthday, whichever is less)

Reference

Ryclora (dexchlorpheniramine) [package insert]. Hazlet, NJ: Carwin Pharmaceutical Associates, LLC; January 2024. https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=aa4f80c9-e600-4bc0-8528-02a8162a36f0

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