Prescriber Criteria Form
HRM Promethazine 2025 PA Fax 1413-B v2 010125.docx
High Risk Medications (HRM) Criteria – Antihistamines
Promethazine injection, suppositories, syrup, tablets
This HRM list applies to formulary drugs only.
Prior Authorization applies only to patients 70 years of age or older.
Prior Authorization applies to greater than cumulative 30 days of therapy per year.
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of HRM Promethazine.

Drug Name (select from list of drugs shown):

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Is the requested drug being prescribed for the treatment of rhinitis? [If no, then skip to question 5.]	Yes ◯	No ◯
2	The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored. Has the patient tried two of the following non-HRM (non-High Risk Medication) alternative drugs: levocetirizine, azelastine nasal, fluticasone nasal, or flunisolide nasal? [If no, then no further questions.]	Yes ◯	No ◯
3	Has the patient experienced an inadequate treatment response or intolerance to two of the following non-HRM (non-High Risk Medication) alternative drugs: levocetirizine, azelastine nasal, fluticasone nasal, or flunisolide nasal? [If no, then no further questions.]	Yes ◯	No ◯
4	Does the benefit of therapy with this prescribed medication outweigh the potential risks for this patient? [No further questions.]	Yes ◯	No ◯

5	Is the requested drug being prescribed for antiemetic therapy in postoperative patients or motion sickness? [If yes, then skip to question 8.]	Yes ◯	No ◯
6	Is the drug being prescribed for the treatment of urticaria? [If yes, then skip to question 8.]	Yes ◯	No ◯
7	Is the requested drug being prescribed for any of the following: A) allergic conjunctivitis, B) dermatographism, C) allergic reaction to blood or plasma, D) sedation, E) adjunct therapy with analgesics for postoperative pain, F) angioedema, G) adjunct therapy with epinephrine for anaphylaxis after acute symptoms are controlled? [If no, then no further questions.]	Yes ◯	No ◯
8	The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored. Does the benefit of therapy with this prescribed medication outweigh the potential risks for this patient?	Yes ◯	No ◯

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ **Date:**_____