Prescriber Criteria Form

HRM Hydroxyzine Inj 2024 PA Fax 1415-B v1 010124.docx
High Risk Medications (HRM) Criteria – Antihistamines
Hydroxyzine hcl injection
This HRM List Applies To Formulary Drugs Only.
Prior Authorization applies only to patients 70 years of age or older
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 Hydroxyzine hcl injection.

Drug Name:
Hydroxyzine hcl injection

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 Alcohol Withdrawal Syndrome? [If no, then skip to question 6.]	Yes	No
2	The American Geriatrics Society identifies the use of this medication as 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 one of the following alternative drugs: clorazepate or lorazepam? [If yes, then skip to question 4.]	Yes	No
3	Does the patient have a contraindication to one of the following alternative drugs: clorazepate or lorazepam? [If yes, then skip to question 5.] [If no, then no further questions.]	Yes	No
4	Has the patient experienced an inadequate treatment response OR intolerance to one of the following alternative drugs: clorazepate or lorazepam? [If no, then no further questions.]	Yes	No

5	Does the benefit of therapy with this prescribed medication outweigh the potential risks for this patient? [No further questions.]	Yes	No
6	Is the requested drug being prescribed for the treatment of nausea/vomiting? [If no, then skip to question 8.]	Yes	No
7	The American Geriatrics Society identifies the use of this medication as 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? [No further questions.]	Yes	No
8	Is the requested drug being prescribed for the treatment of anxiety? [If no, then no further questions.]	Yes	No
9	The American Geriatrics Society identifies the use of this medication as 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 alternative drugs: buspirone, duloxetine, escitalopram, sertraline or venlafaxine extended-release? [If no, then skip to question 11.]	Yes	No
10	Has the patient experienced an inadequate treatment response OR intolerance to two of the following alternative drugs: buspirone, duloxetine, escitalopram, sertraline or venlafaxine extended-release? [If yes, then skip to question 12.] [If no, then no further questions.]	Yes	No
11	Is the requested drug being prescribed for the treatment of acute anxiety? [If no, then no further questions.]	Yes	No
12	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:**_____