

# Hydroxyzine/Hydroxyzine Pamoate Coverage Determination



Mail requests to: Coverage Determination & Exceptions  
 PO Box 20002 Nashville, TN 37202  
 Fax requests to: (866) 845-7267  
 Request by phone: (877) 813-5595

## FOR PROVIDER USE ONLY

<b>Office Contact:</b>		<b>Provider Specialty:</b>	
<b>Provider First Name:</b>		<b>Provider Last Name:</b>	
<b>Provider Phone:</b>		<b>Provider Fax:</b>	
<b>Provider Address:</b>			
<b>License Number:</b>	<b>DEA Number:</b>	<b>NPI Number:</b>	

**Customer Name:** \_\_\_\_\_

**Customer Address:** \_\_\_\_\_

<b>Customer Phone:(H)</b>	<b>(C)</b>
<b>Customer ID:</b>	<b>DOB:</b>

Rx Prescription Information				
Drug:	Dosage:	Frequency:	Quantity:	
<input type="checkbox"/> <b>Brand</b> <input type="checkbox"/> <b>Generic</b> <input type="checkbox"/> <b>New Medication</b> <input type="checkbox"/> <b>Continuation (Provide Start Date)</b>	<b>Refills:</b>			

Please select from the following diagnoses:

**Anxiety:** \_\_\_\_\_

**Itching:** \_\_\_\_\_

**Nausea/Vomiting (indication for IM product only):** \_\_\_\_\_

**Sedation (adjunctive):** \_\_\_\_\_

**Interstitial cystitis:** \_\_\_\_\_

(Start and End Dates): \_\_\_\_\_

<b>Formulary Agents for Anxiety:</b>	<b>Formulary Agents for Itching:</b>	<b>Formulary Agent for Nausea/Vomiting:</b>
Buspirone: _____	Levocetirizine: _____	Ondansetron: _____
Fluoxetine: _____	Desloratadine: _____	
Citalopram: _____	Topical Steroids: _____	
Venlafaxine: _____	Ammonium Lactate: _____	
Paroxetine: _____		

**Formulary Agent for Interstitial Cystitis:**

Desipramine: \_\_\_\_\_

List any adverse reaction, negative outcome, or intolerance Customer has experienced with above agents:

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Is the request for an inpatient that is awaiting discharge?                      Yes                      No

**Plan requires a 30 day minimum trial and failure of at least 2 formulary agents.**

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***By Checking this box, I certify that I have reviewed the clinical information needed for approval, and have no further information to provide regarding this request.***

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***Request for expedited review [24 hours]. By checking this box, I certify that applying the 72 hour standard review time frame may seriously jeopardize the life or health of the Customer or the Customer's ability to regain maximum function.***

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**Provider Signature:**

**Date:**

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