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

Office Contact:	**Provider Specialty:**
Provider First Name:	**Provider Last Name:**
Provider Phone:	**Provider Fax:**

Provider Address:

License Number:	**DEA Number:**	**NPI Number:**

Customer Name:

Customer Address:

Customer Phone:(H)	**(C)**
Customer ID:	**DOB:**

Rx **Prescription Information**

Drug:	**Dosage:**	**Frequency:**	**Quantity:**

□ **Brand**	□ **Generic**	□ **New Medication**	□ **Continuation (Provide Start Date)**	**Refills:**

Please select from the following diagnoses:

Anxiety: _____
Itching: _____
Nausea/Vomiting (indication for IM product only): _____
Sedation (adjunctive): _____
Interstitial cystitis: _____
(Start and End Dates):

Formulary Agents for Anxiety:
Buspirone: _____
Fluoxetine: _____
Citalopram: _____
Venlafaxine: _____
Paroxetine: _____

Formulary Agents for Itching:
Levocetirizine: _____
Desloratadine: _____
Topical Steroids: _____
Ammonium Lactate: _____

Formulary Agent for Nausea/Vomiting:
Ondansetron: _____

Formulary Agent for Interstitial Cystitis:
Desipramine: _____

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

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.

☐ ***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.***

☐ ***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.***

Provider Signature: **Date:**