Please note: All information below is required to process this request
Mon-Fri: 5am to10pm Pacific / Sat: 6am to 3pm Pacific
For real time submission 24/7 visit www.OptumRx.com and click Health Care Professionals
OptumRx • M/S CA 106-0286 • 3515 Harbor Blvd. • Costa Mesa, CA 92626

Meclizine Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Motion sickness
❑ Radiation-induced vomiting (treatment or prophylaxis)
❑ Vertigo
❑ Other diagnosis: _____ ICD-9/10 Code(s): _____

The approval criteria is based on the guidance provided by the Centers for Medicare & Medicaid Services (CMS), the Pharmacy Quality Alliance, the American Geriatric Society and the National Committee for Quality Assurance (NCQA). "Use of High Risk Medications in the Elderly" is measure 238 of the Centers for Medicare & Medicaid Services Physician Quality Reporting System.

Risk acknowledgment:

Does the provider acknowledge that this drug has been identified by the Centers for Medicare and Medicaid Services as a high risk medication in the 65 and older population? ❑ **Yes** ❑ **No**

Has the provider submitted an adequate monitoring plan for adverse reactions with use of this high risk medication? ❑ **Yes** ❑ **No**

***Please note: Chart documentation of the above is required to be submitted to OptumRx®.*

Coverage of the drug is approvable after demonstrated failure to the alternatives below or we receive information as to why they would be inappropriate.

Select the medications the patient has a failure, contraindication, or intolerance to:

❑ Compro, prochlorperazine, prochlorperazine maleate
❑ Granisetron
❑ Meclizine 12.5mg tablet
❑ Ondansetron
❑ Prochlorperazine edisylate

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

Please note: This request may be denied unless all required information is received.
If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.