OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Hydroxyzine Products Prior Authorization Request Form (Page 1 of 2)

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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:
❑ Anxiety
❑ Seasonal allergic rhinitis
❑ Pruritus
❑ Sedation (Premedication and following general anesthesia)
❑ Other diagnosis: ____________________________ ICD-10 Code(s): ____________________________

If the patient has End-Stage Renal Disease (ESRD), select all that apply:
❑ The medication is being used to treat itching secondary to dialysis
❑ The dialysis provider (i.e., nephrologist, nurse practitioner, physician assistant, or dialysis center) receives a monthly capitation payment to manage the ESRD patient's care

Part B vs D questionnaire:
Will this anti-emetic be initiated within 2 hours of administration of chemotherapy AND continued for a period not to exceed 48 hours from that time? ❑ **Yes** ❑ **No**

Will this anti-emetic be used as a full therapeutic replacement for intravenous (IV) anti-emetic therapy that would have been administered at the time of the cancer chemotherapy treatment? ❑ **Yes** ❑ **No**

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**

Does the provider wish to proceed with the originally prescribed medication? ❑ **Yes** ❑ **No**

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

Anxiety:
Select the medications the patient has a failure, contraindication, or intolerance to:
❑ Buspirone
❑ Cymbalta
❑ Duloxetine 20mg, 30mg, 60mg
❑ Duloxetine 40mg
❑ Effexor XR
❑ Escitalopram
❑ Hydroxyzine hydrochloride (HCl) syrup
❑ Hydroxyzine HCl tablet
❑ Hydroxyzine pamoate
❑ Lexapro
❑ Mirtazapine
❑ Paroxetine
❑ Paxil
❑ Pexeva
❑ Sertraline
❑ Venlafaxine ER capsule
❑ Venlafaxine ER tablet

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Hydroxyzine Products Prior Authorization Request Form (Page 2 of 2)

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Pruritus:

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

- ❑ Cetirizine syrup
- ❑ Clarinex
- ❑ Clarinex-D 12 hour
- ❑ Desloratadine
- ❑ Desloratadine ODT
- ❑ Hydroxyzine HCl syrup
- ❑ Hydroxyzine HCl tablet
- ❑ Hydroxyzine pamoate
- ❑ Levocetirizine
- ❑ Topical Alclometasone

Seasonal allergic rhinitis:

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

- ❑ Astepro
- ❑ Azelastine nasal spray
- ❑ Beconase AQ
- ❑ Cetirizine syrup
- ❑ Clarinex
- ❑ Clarinex-D 12 Hour
- ❑ Desloratadine
- ❑ Desloratadine ODT
- ❑ Flunisolide nasal spray
- ❑ Fluticasone nasal spray
- ❑ Hydroxyzine HCl syrup
- ❑ Hydroxyzine HCl tablet
- ❑ Hydroxyzine pamoate
- ❑ Levocetirizine
- ❑ Mometasone nasal spray
- ❑ Nasonex
- ❑ Olopatadine nasal spray
- ❑ Omnaris
- ❑ Patanase
- ❑ Qnasl
- ❑ Qnasl Children's
- ❑ Triamcinolone nasal spray
- ❑ Xhance
- ❑ Zetonna

Sedation (Premedication and following general anesthesia):

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

- ❑ Hydroxyzine HCl syrup
- ❑ Hydroxyzine HCl tablet
- ❑ Hydroxyzine pamoate

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

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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.

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