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Visit [go.covermymeds.com/OptumRx](http://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

## Promethazine Products Prior Authorization Request Form (Page 1 of 2)

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Member Information <small>(required)</small>			Provider Information <small>(required)</small>		
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 <small>(required)</small>					
Medication Name:			Strength:		Dosage Form:
<input type="checkbox"/> Check if requesting <b>brand</b>			Directions for Use:		
<input type="checkbox"/> Check if request is for <b>continuation of therapy</b>					
Clinical Information <small>(required)</small>					
<b>Select the diagnosis below:</b>					
<input type="checkbox"/> Allergic conjunctivitis		<input type="checkbox"/> Hypersensitivity reaction to blood or plasma		<input type="checkbox"/> Post-operative pain (adjunct therapy with Meperidine/other analgesics)	
<input type="checkbox"/> Allergic rhinitis (perennial or seasonal)		<input type="checkbox"/> Nausea and vomiting (N/V) Is the N/V due to anesthesia and surgery (prevention and control)? <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Preoperative, postoperative, or obstetric sedation	
<input type="checkbox"/> Anaphylaxis (adjunct to epinephrine)		Is the N/V due to labor? <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Sedation, relief of apprehension, & production of light sleep from which patient can be easily aroused	
<input type="checkbox"/> Angioedema		Is the N/V due to motion sickness? <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Urticaria	
<input type="checkbox"/> Dermatographism		Is the N/V due to post-operative N/V? <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Vasomotor rhinitis	
<input type="checkbox"/> Other diagnosis: _____		ICD-10 Code(s): _____			
<b>If the patient has End-Stage Renal Disease (ESRD), select all that apply:</b>					
<input type="checkbox"/> The medication is being used to treat/prevent nausea and vomiting secondary to dialysis					
<input type="checkbox"/> 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					
<b>Part B vs D questionnaire:</b>					
Will this anti-emetic be <u>initiated within 2 hours</u> of administration of chemotherapy AND continued for a period <u>not to exceed 48 hours</u> from that time? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No					
<b><i>The approval criteria is based on the guidance provided by the Centers for Medicare &amp; 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 &amp; Medicaid Services Physician Quality Reporting System.</i></b>					
<b>Risk acknowledgment:</b>					
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? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Does the provider wish to proceed with the originally prescribed medication? <input type="checkbox"/> Yes <input type="checkbox"/> No					

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of OptumRx. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**

Office use only: PromethazineProducts\_CMS\_2019Feb-W



## Promethazine Products Prior Authorization Request Form (Page 2 of 2)

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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:

- |                                                                           |                                                          |                                                         |
|---------------------------------------------------------------------------|----------------------------------------------------------|---------------------------------------------------------|
| <input type="checkbox"/> Astepro                                          | <input type="checkbox"/> Levocetirizine                  | <input type="checkbox"/> Promethazine 50mg suppository  |
| <input type="checkbox"/> Azelastine nasal spray                           | <input type="checkbox"/> Mometasone nasal spray          | <input type="checkbox"/> Promethazine solution          |
| <input type="checkbox"/> Beconase AQ                                      | <input type="checkbox"/> Nasonex                         | <input type="checkbox"/> Promethazine syrup             |
| <input type="checkbox"/> Cetirizine syrup                                 | <input type="checkbox"/> Olopatadine nasal spray         | <input type="checkbox"/> Promethazine tablet            |
| <input type="checkbox"/> Clarinex                                         | <input type="checkbox"/> Omnaris                         | <input type="checkbox"/> Promethegan 12.5mg suppository |
| <input type="checkbox"/> Clarinex D 12-hour                               | <input type="checkbox"/> Ondansetron                     | <input type="checkbox"/> Promethegan 25mg suppository   |
| <input type="checkbox"/> Clemastine                                       | <input type="checkbox"/> Ondansetron ODT                 | <input type="checkbox"/> Promethegan 50mg suppository   |
| <input type="checkbox"/> Compro                                           | <input type="checkbox"/> Patanase                        | <input type="checkbox"/> Qnasl                          |
| <input type="checkbox"/> Cyproheptadine                                   | <input type="checkbox"/> Perphenazine                    | <input type="checkbox"/> Qnasl Children's               |
| <input type="checkbox"/> Desloratadine                                    | <input type="checkbox"/> Phenadoz                        | <input type="checkbox"/> Sancuso                        |
| <input type="checkbox"/> Desloratadine orally disintegrating tablet (ODT) | <input type="checkbox"/> Prochlorperazine                | <input type="checkbox"/> Semprex-D                      |
| <input type="checkbox"/> Flunisolide nasal spray                          | <input type="checkbox"/> Prochlorperazine maleate        | <input type="checkbox"/> Triamcinolone nasal spray      |
| <input type="checkbox"/> Fluticasone nasal spray                          | <input type="checkbox"/> Promethazine 12.5mg suppository | <input type="checkbox"/> Xhance                         |
| <input type="checkbox"/> Granisetron                                      | <input type="checkbox"/> Promethazine 25mg suppository   | <input type="checkbox"/> Zetonna                        |

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.