



Please complete ALL information below and fax your request to 1-888-671-5285

Hydroxyzine Products Coverage Determination 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:	Office Contact:	
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name: Select one of the following: <input type="checkbox"/> Request is for GENERIC <input type="checkbox"/> Request is for BRAND (unable to take the generic)	Strength:	Dosage Form:
<input type="checkbox"/> Check if request is for continuation of therapy	Directions for Use:	

Clinical Information (required)	
Select the Type(s) of Coverage Determination Requested:	
<input type="checkbox"/> Non-Formulary - Request is for a drug not on the plan's list of covered drugs OR was previously included on the plan's list is being/was removed from this list during the plan year.	
<input type="checkbox"/> Prior Authorization - Request is for a drug that requires prior authorization under the plan.	
Select the diagnosis below:	
<input type="checkbox"/> Anxiety	
<input type="checkbox"/> Pruritus	
<input type="checkbox"/> Seasonal allergic rhinitis	
<input type="checkbox"/> Sedation (Premedication and following general anesthesia)	
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____	

Clinical information: Is there documentation that the risk versus benefit has been assessed for this request of a high risk medication (HRM) in an elderly patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Medication history:
Anxiety: Select the medication(s) the patient has a history of trial and failure, or intolerance to:
<input type="checkbox"/> Hydroxyzine tablet
<input type="checkbox"/> Other drugs in the same class. Please specify: _____
<input type="checkbox"/> Other therapeutic equivalent alternatives. Please specify: _____
Pruritus: Select the medication(s) the patient has a history of trial and failure, or intolerance to:
<input type="checkbox"/> Clarinex
<input type="checkbox"/> Desloratadine
<input type="checkbox"/> Hydroxyzine tablet
<input type="checkbox"/> Levocetirizine
<input type="checkbox"/> Other drugs in the same class. Please specify: _____
<input type="checkbox"/> Other therapeutic equivalent alternatives. Please specify: _____

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 FutureScripts. 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: HydroxyzineProducts_FSPartD_2019Apr-W



Hydroxyzine Products Coverage Determination Request Form (Page 2 of 2)

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Seasonal allergic rhinitis:

Select the medication(s) the patient has a history of trial and failure, or intolerance to:

- Azelastine nasal spray
- Clarinex
- Desloratadine
- Hydroxyzine tablet
- Levocetirizine
- Olopatadine nasal spray
- Other drugs in the same class. Please specify: _____
- Other therapeutic equivalent alternatives. Please specify: _____

Sedation (Premedication and following general anesthesia):

Select the medication(s) the patient has a history of trial and failure, or intolerance to:

- Hydroxyzine tablet
- Other drugs in the same class. Please specify: _____
- Other therapeutic equivalent alternatives. Please specify: _____

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.