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

# Phenergan® (promethazine) injection Coverage Determination 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: | Office Contact: | |
| City: | State: | Zip: | Office Street Address: | | |
| Phone: | | | City: | State: | Zip: |

## Medication Information (required)

| | | |
|---|---|---|
| Medication Name:<br>Select one of the following:<br>❑ Request is for **GENERIC**<br>❑ Request is for **BRAND** (unable to take the generic) | Strength: | Dosage Form: |
| ❑ Check if request is for **continuation of therapy** | Directions for Use: | |

## Clinical Information (required)

**Select the Type(s) of Coverage Determination Requested:**

❑ **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.

❑ **Prior Authorization**- Request is for a drug that requires prior authorization under the plan.

**Provide the diagnosis:** ____________________________________ ICD-10 Code(s): ____________________________________

**Medication History:**

**For brand Phenergan injection:**

List the medication(s) (in the **same class**) the patient has a history of trial and failure, or intolerance to: __________________________

______________________________________________________________________________________________________________

List the medication(s) (that are **therapeutic equivalent alternatives**) the patient has a history of trial and failure, or intolerance to: ______

______________________________________________________________________________________________________________

**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? ❑ **Yes** ❑ **No**

**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.

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.**