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

Promethazine Products 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: Select one of the following: ❑ Request is for **GENERIC** ❑ 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:

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

Select the diagnosis below:

❑ Adjunctive therapy for control of post-operative pain
❑ Allergic conjunctivitis
❑ Allergic rhinitis (perennial or seasonal)
❑ Anaphylaxis (adjunct to epinephrine)
❑ Angioedema
❑ Dermatographism
❑ Hypersensitivity reaction to blood or plasma
❑ Motion sickness
❑ Nausea and vomiting due to anesthesia and surgery
❑ Preoperative, postoperative, or obstetric sedation
❑ Sedation (adults and children needing relief from light sleep arousal)
❑ Urticaria
❑ Vasomotor rhinitis
❑ 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? ❑ **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?

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Please note: This request may be denied unless all required information is received.

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