Prescriber Criteria Form

HRM Doxepin 2026 PA Fax 4437-B v1 010126.docx
High Risk Medications (HRM) Criteria – Tricyclic Antidepressants (TCA)
doxepin capsules, solution (applies to greater than 6 mg daily)
This HRM List applies to formulary drugs only.
Prior Authorization applies only to patients 65 years of age or older.
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of doxepin capsules, solution (applies to greater than 6 mg daily).

Drug Name:
doxepin capsules, solution (applies to greater than 6 mg daily)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored. Is the requested drug being prescribed for the treatment of anxiety? [If no, then skip to question 4.]	Yes	No
2	Has the patient tried two of the following alternative drugs: buspirone, duloxetine, escitalopram, sertraline, or venlafaxine extended-release? [If no, then no further questions.]	Yes	No
3	Has the patient experienced an inadequate treatment response or intolerance to two of the following alternative drugs: buspirone, duloxetine, escitalopram, sertraline, or venlafaxine extended-release? [If yes, then skip to question 7.] [If no, then no further questions.]	Yes	No
4	The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored. Is the requested drug being prescribed for the treatment of depression? [If no, then no further questions.]	Yes	No

5	Has the patient tried two of the following alternative drugs: SSRIs (selective serotonin reuptake inhibitors), SNRIs (serotonin-norepinephrine reuptake inhibitors), bupropion, mirtazapine, or trazodone? [If no, then no further questions.]	Yes	No
6	Has the patient experienced an inadequate treatment response or intolerance to two of the following alternative drugs: SSRIs (selective serotonin reuptake inhibitors), SNRIs (serotonin-norepinephrine reuptake inhibitors), bupropion, mirtazapine, or trazodone? [If no, then no further questions.]	Yes	No
7	Does the benefit of therapy with this prescribed medication outweigh the potential risks for this patient? [If no, then no further questions.]	Yes	No
8	Is the patient using one or more additional anticholinergic medications (e.g., oxybutynin, meclizine, paroxetine, amitriptyline, dicyclomine, hydroxyzine) with the requested drug? [If no, then no further questions.]	Yes	No
9	Has the prescriber determined that taking multiple anticholinergic medications is medically necessary for the patient? [Note: Use of multiple anticholinergic medications in older adults is associated with an increased risk of cognitive decline.]	Yes	No

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ **Date:**_____