Prescriber Criteria Form

HRM Hydroxyzine Oral PA Plus 2026 PA Fax 1414-B v1 010126.docx
High Risk Medications (HRM) Criteria – Antihistamines
hydroxyzine HCl oral, Vistaril (hydroxyzine pamoate)
This HRM List applies to formulary drugs only.
Prior Authorization applies only to patients 65 years of age or older.
Prior Authorization applies to greater than cumulative 30 days of therapy per year.
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 Hydroxyzine Oral.

Drug Name (select from list of drugs shown):

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	Is the requested drug being prescribed for the treatment of pruritus? [If no, then skip to question 3.]	Yes	No
2	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. Does the benefit of therapy with this prescribed medication outweigh the potential risks for this patient? [If yes, then skip to question 8.] [If no, then no further questions.]	Yes	No
3	Is the requested drug being prescribed for the treatment of anxiety? [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. Has the patient tried two of the following alternative drugs: buspirone, duloxetine, escitalopram, sertraline or venlafaxine extended-release? [If no, then skip to question 6.]	Yes	No

5	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
6	Is the requested drug being prescribed for the treatment of acute anxiety? [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, cyclobenzaprine) 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:**_____