Prescriber Criteria Form HRM Low Impact 2026 PA Fax 1422-B v1 010126.docx High Risk Medications (HRM) Criteria This HRM List applies to formulary drugs only. Prior Authorization applies only to patients 65 years of age or older	
Antiarrhythmic	Disopyramide, Disopyramide Extended Release (Norpace CR)
Antineoplastic	Megestrol Tablets, Suspension (not including Megestrol ES Suspension 625mg/5ml)
Antihistamine	Carbinoxamine, Clemastine, Dexchlorpheniramine, Diphenhydramine Oral, Promethazine/Phenylephrine
Antiplatelet	Dipyridamole
Antipsychotic-Antidepressant Combination	Perphenazine/Amitriptyline
Cardiovascular	Digoxin (applies to greater than 0.125mg Daily)
Estrogens	Bijuva (estradiol/progesterone), Premarin Oral (conjugated estrogens oral), Conjugated Estrogen Synthetic A And B, Prempro, Premphase (conjugated estrogens/medroxyprogesterone acetate), Duavee (conjugated estrogens/bazedoxifene), estradiol oral, topical, esterified estrogens, estradiol-norethindrone oral, topical, estradiol-estradiol-norgestimate, estropipate, estradiol-levonorgestrel
Non-Steroidal Anti-Inflammatory	Ketorolac Tromethamine Tablets
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 HRM Low Impact.	

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	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	Yes	No

	the benefit of therapy with this prescribed medication outweigh the potential risks for this patient?		

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:_____