Prescriber Criteria Form

HRM Meclizine PA Plus 2026 PA Fax 4555-B v1 010126.docx
High Risk Medications (HRM) - Antihistamines
meclizine
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 meclizine.

Drug Name:
meclizine

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 any of the following: A) treatment of vertigo associated with diseases affecting the vestibular system, B) prevention or treatment of nausea, vomiting, and dizziness associated with motion sickness, C) treatment or prophylaxis of radiation-induced nausea and vomiting? [If no, then no further questions.]	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 no, then no further questions.]	Yes	No
3	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
4	Has the prescriber determined that taking multiple anticholinergic medications is medically necessary for the patient?	Yes	No

	[Note: Use of multiple anticholinergic medications in older adults is associated with an increased risk of cognitive decline.]		

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:**_____