PriorityHealth

Priority Health Medicare prior authorization form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☐ **Medicare Part B** ☒ **Medicare Part D**
This request is: ☐ **Expedited request** ☐ **Standard request**

Your request will be expedited if you haven't gotten the prescription and Priority Health Medicare determines, or your prescriber tells us, that your life or health may be at risk by waiting.

Promethazine tablets

Member

Last Name: ______________________ First Name: ______________________
ID #: ______________________ DOB: ____________ Gender: ____________
Primary Care Physician: ______________________

Requesting Provider: ______________________ Prov. Phone: ____________ Prov. Fax: ____________
Provider Address: ____
Provider NPI: ______________________ Contact Name: ______________________

Provider Signature: ______________________ Date: ____________

Product Information

☐ New request ☐ Continuation request

Drug product:
- ☐ Promethazine 12.5 mg tablet
- ☐ Promethazine 25 mg tablet
- ☐ Promethazine 50 mg tablet

Start date (or date of next dose): ____________
Date of last dose (if applicable): ____________
Dosing frequency: ____________

Precertification Requirements

The following requirements need to be met before this drug is covered by Priority Health Medicare. These requirements have been approved by the Centers for Medicare and Medicaid Services (CMS), but you may ask us for an exception if you believe one or more of these requirements should be waived.

1. Must have an FDA-approved indication, not otherwise excluded from Medicare Part D, and meet the following criteria:
   - For allergic condition
     - Must first try desloratidine or levocetirizine
   - For motion sickness
     - Must first try meclizine or Transderm Scop
   - For nausea and vomiting
     - Must first try prochlorperazine

Note: Promethazine suppositories are available on the formulary and do not require prior authorization.

Medically accepted indication

This drug is only covered under Medicare Part D when it is used for a medically accepted indication. A medically accepted indication is a use of the drug that is *either*:

- approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
  — *or* — supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information and the DRUGDEX Information System)

All fields must be complete and legible for review. Your office will receive a response via fax.

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Priority Health Precertification Documentation

Covered condition **(Place an "X" in the box for the condition this drug is being requested for.)**	**Requirements that must be met before the drug is covered** **(Place an "X" in the appropriate box to indicate the patient has met the required criteria.)**
☐ Allergic condition	Has the patient one of the following: ☐ Desloratidine ☐ Levocetirizine
☐ Motion sickness	Has the patient one of the following: ☐ Meclizine ☐ Transderm Scop
☐ Nausea and vomiting	Has the patient one of the following: ☐ prochlorperazine

Priority Health Medicare exception request

Do you believe one or more of the prior authorization requirements should be waived? ☐ Yes ☐ No
If yes, you must provide a statement explaining the medical reason why the exception should be approved.

Would promethazine likely be the most effective option for this patient?
☐ Yes ☐ No
If yes, please explain why: ____

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If the patient is currently using promethazine, would changing the patient's current regimen likely result in adverse effects for the patient?
☐ Yes ☐ No
If yes, please explain: ____

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All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 12/2017
Last reviewed 01/2019