Medicare Part D Coverage Determination Request Form for Hydroxyzine

Instructions: Please complete ALL FIELDS and fax this form to WellCare’s Pharmacy Department at **1-877-277-1809**.
Formulary and utilization management criteria may be reviewed at **www.easychoicehealthplan.com**

Who is making this request? Provider ☐
Appointed Representatives: Please include a signed Appointment of Representative form (CMS-1696) or equivalent notice.

☐ **REQUEST FOR EXPEDITED REVIEW (24 HOURS)**
By checking the expedited box, the requestor certifies that applying the 72-hour standard review time frame may seriously jeopardize the life or health of the member or the member’s ability to regain maximum function.

***REQUIRED FIELDS – ONE medication per form**

*Member Name:		*Date of Request:	
*<WellCare/‘Ohana/Easy Choice> ID #:	*Date of Birth:	*Physician FULL Name/Specialty:	
*Member’s Telephone Number:		*Physician Signature:	
*Diagnosis of Requested Medication:		*Contact Name at MD Office:	*Physician NPI:
*Medication, Strength, and Route of Administration:		*Physician Phone #:	*Physician Fax #:
		Pharmacy Name:	Pharmacy Phone #:
*Frequency:	*Quantity:	*Duration of Therapy:	*Drug Allergies:

PLEASE COMPLETE THIS SECTION IF THE PATIENT IS 65 OR OLDER:

1) Has the patient tried a non-high risk medication (HRM) alternative formulary drug?
(***For pruritus: levocetirizine; for anxiety (at least two): buspirone, duloxetine, escitalopram, sertraline, or venlafaxine ER***)
☐YES ☐NO

2) Does the patient have a contraindication, intolerance, or an inadequate treatment response to a non-HRM alternative formulary drug?
(For pruritus: levocetirizine; for anxiety (at least two): buspirone, duloxetine, escitalopram, sertraline, or venlafaxine ER)?
☐YES ☐NO

3) Does the benefit of therapy with this prescribed medication outweigh the potential risk in the patient 65 or older?
☐YES ☐NO

Rationale for Request:

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