Updated: 02/2019
PARP Approved: 03/2019

Prior Authorization Criteria

Cough and Cold Medications for Children Less than 4 Years

All requests for Cough and Cold Medications for Children Less than 4 Years require a prior authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Cough and Cold Medications for Children Less than 4 Years Prior Authorization Criteria:

For all requests for Cough and Cold Medications for Children Less than 4 Years all of the following criteria must be met:

1) Member must have a history of trial and failure with ONE of the following treatments:
    - Cool mist humidifier/vaporizer
    - Saline nose drops or spray
    - Nasal Aspirator
2) Medication must be packaged and labeled for pediatric use
3) A review of active authorizations will be completed to ensure no duplication of active ingredients
4) The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines

- **Initial Duration of Approval:** 10 days
- **Reauthorization criteria**
    - A chart documented evaluation for other diagnoses (such as allergies, bronchitis, pneumonia) if symptoms last longer than 10 days
- **Reauthorization Duration of Approval:** 10 days

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

Gateway Health

Updated: 02/2019
PARP Approved: 03/2019

COUGH AND COLD MEDICATIONS FOR CHILDREN LESS THAN 4 YEARS
PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Gateway Health℠ Pharmacy Services. **FAX:** (888) 245-2049
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (800) 392-1147 Monday through Friday 8:30am to 5:00pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:
Gateway ID:	Member weight: _____pounds or _____kg

REQUESTED DRUG INFORMATION

Medication:	Strength:
Frequency:	Duration:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:

Billing Information

This medication will be billed: ☐ at a pharmacy **OR**
☐ medically (if medically please provide a JCODE:_____

Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Is the medication packaged and labeled for pediatric use? ☐ Yes ☐ No
Will the member be using any other medications that will result in a duplicate therapy? ☐ Yes ☐ No
Has the patient tried and failed the following treatments?
Humidifier or vaporizer: ☐ Yes ☐ No
Saline nasal drops: ☐ Yes ☐ No
Nasal aspirator: ☐ Yes ☐ No

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

REAUTHORIZATION

Please provide the associated diagnosis if therapy is required for greater than 10 days:

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date