Updated: 02/2022
DMMA Approved: 02/2022

Request for Prior Authorization for Cough and Cold Medications for Children
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

All requests for Opioid Cough and Cold Medications for Children will be reviewed under policy CP.206.216-MD-DE Age Edits. All request for Non-Opioid 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 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:

- 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
- Medication must be packaged and labeled for pediatric use
- A review of active authorizations will be completed to ensure no duplication of active ingredients
- 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.

Drugs are authorized in generic form unless the branded product is on the preferred drug list or the prescriber has indicated in writing that the branded product is medically necessary. If only the branded product is on the preferred drug list, the generic form will be considered non-preferred and shall not require the prescriber to indicate in writing that the branded product is medically necessary.

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COUGH AND COLD MEDICATIONS FOR CHILDREN
PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX:** (855) 476-4158
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (844) 325-6251 Monday through Friday 8:00am to 7:00pm

PROVIDER INFORMATION

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

MEMBER INFORMATION

Member Name:	DOB:
Health Options 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:

Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? ☐ Yes ☐ No

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

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