

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

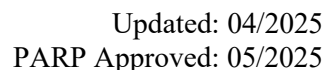
All requests for Cough and Cold Medications for Children Less than 4 years require a prior authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

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 the following treatments:
 - Cool mist humidifier/vaporizer
 - Saline nose drops or spray
 - Nasal Aspirator
- Medications 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.

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.



Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Wholecare Pharmacy Services. **FAX:** (888) 245-2049

If needed, you may call to speak to a Pharmacy Services Representative. **PHONE:** (800) 392-1147 Mon-Fri 8:30am to 5:00pm

Requesting Provider:	Provider NPI:
Provider Specialty:	Office Contact:
State license #:	Office NPI:
Office Address:	Office Phone:
	Office Fax:

Member Name:	DOB:	
Member ID:	Member weight:	Height:

Medication:		Strength:	
Directions:		Quantity:	Refills:
Is the member currently receiving requested medication?		<input type="checkbox"/> Yes <input type="checkbox"/> No	Date Medication Initiated:

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

Name:	NPI:
Address:	Phone:

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

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

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

Date _____

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