UnitedHealthcare Community Plan

Clinical Pharmacy Program Guidelines for Phenergen and Phenergen-containing Products

Program	Prior Authorization
Medication	Phenergan and Phenergan Containing Products

1. Background:

Drugs Requiring Prior Authorization

PHENADOZ® 12.5 MG SUPPOSITORY	PROMETHAZINE 25 MG TABLET
PHENADOZ 25 MG SUPPOSITORY	PROMETHAZINE 50 MG TABLET
PHENERGAN 25 MG/ML AMPUL	PROMETHAZINE 25 MG/ML VIAL
PHENERGAN 50 MG/ML AMPUL	PROMETHAZINE 50 MG/ML VIAL
PHENERGAN 25 MG/ML VIAL	PROMETHAZINE VC SYRUP
PHENERGAN 50 MG/ML VIAL	PROMETHAZINE VC-CODEINE SYRUP
PROMETHAZINE 25 MG/ML AMPUL	PROMETHAZINE-CODEINE SYRUP
PROMETHAZINE 50 MG/ML AMPUL	PROMETHAZINE-DM SYRUP
PROMETHAZINE 12.5 MG SUPPOS	PROMETHEGAN™ 12.5 MG SUPPOS
PROMETHAZINE 25 MG SUPPOSITORY	PROMETHEGAN 25 MG SUPP
PROMETHAZINE 6.25 MG/5 ML SYRP	PROMETHEGAN 50 MG SUPPOSITORY
PROMETHAZINE 12.5 MG TABLET	

2. Coverage Criteria:

A. <u>Authorization Criteria</u>

1. The patient is at least 2 years of age.

Authorization will be issued for 365 days.

Program	Program type – Prior Authorization
Change Control	
Date	Change
August 1, 2016	New program