

# Pharmacy Prior Authorization Form

Last Reviewed: July 09

For Prior Authorization please fax to: (877)974-4411 toll free, or (616)942-8206

This form applies to:  Commercial Plan  Medicaid Plan  Medicare Plan

## Intravenous 5-HT3 Antagonists (Anzemet and Aloxi)

Urgent

Non-urgent

Member Name:	Member #:
DOB:	Gender:
Provider Name:	Provider Phone:
Provider Office Address:	
Provider Office Contact Name:	Provider Fax:
Provider Signature:	Provider NPI:
Date:	Member's PCP:

Product:  Anzemet IV  Aloxi IV

Duration: \_\_\_\_\_ weeks

Dose: \_\_\_\_\_ Start date: \_\_\_\_\_

Place of administration:

Provider's Office

Outpatient Infusion Center

Name of center: \_\_\_\_\_

Home Infusion

Name of agency: \_\_\_\_\_

Billing options:

Physician buy and bill

Preferred Specialty Vendor

Other: \_\_\_\_\_

Diagnosis code: \_\_\_\_\_

*Note: Evidence suggests similar efficacy among all 5-HT3 agents. Use of Anzemet or Aloxi (non-preferred) requires a therapeutic trial and clinical failure with ondansetron IV.*

### FDA approved indication:

5-HT3 antagonists are indicated for the prevention of nausea and vomiting associated with initial and repeat courses of emetogenic cancer chemotherapy and for the prevention and treatment of postoperative nausea and vomiting.

### Priority Health precertification requirements:

1. FDA-approved indication (check which applies):

Prevention of nausea and vomiting associated with emetogenic cancer chemotherapy

Prior use of oral 5-HT3 antagonists is required as evidence suggests similar efficacy between oral and IV formulations for the treatment of chemotherapy-induced nausea/vomiting.

\*Indicate which oral therapy has been used and the date of trial:

Drug: \_\_\_\_\_ Date: \_\_\_\_\_

Prevention and treatment of postoperative nausea and vomiting

**OR**

2. Non-FDA approved indication (off-label):

Indication: \_\_\_\_\_

Two peer-reviewed literature articles supporting the use of the medication being requested for this indication must be provided.

Prior use of the following medications (check which apply):

- Metoclopramide (Reglan)
- Prochlorperazine (Compazine)
- Promethazine (Phenergan)
- Trimethobenzamide (Tigan)
- Oral 5HT-3 Antagonist (Zofran, Anzemet, Kytril)

**Duration of authorization:**

- When approved, authorization will be for the duration of chemotherapy or other approved use

\*\*\* All fields must be complete and legible for Prior Authorization Review\*\*\*

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**YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX**