

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

Antiemetics (ondansetron, granisetron, Anzemet, Emend)

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:

- | | | | |
|-----------------------------------------|-----------------------------------------|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> Ondansetron | <input type="checkbox"/> Granisetron | <input type="checkbox"/> Anzemet | <input type="checkbox"/> Emend |
| <input type="checkbox"/> 4 mg tabs | <input type="checkbox"/> 1 mg tabs | <input type="checkbox"/> 50 mg tabs | <input type="checkbox"/> 40 mg caps |
| <input type="checkbox"/> 8 mg tabs | <input type="checkbox"/> 1 mg/5 ml soln | <input type="checkbox"/> 100 mg tabs | <input type="checkbox"/> 80 mg caps |
| <input type="checkbox"/> 16 mg tabs | | | <input type="checkbox"/> 125 mg caps |
| <input type="checkbox"/> 24 mg tabs | | | |
| <input type="checkbox"/> 4 mg ODT | | | |
| <input type="checkbox"/> 8 mg ODT | | | |
| <input type="checkbox"/> 4 mg/5 ml soln | | | |

Dose: _____ Start date: _____

Priority Health Precertification Requirements:

Authorization of Oral antiemetics require:

- If being used within 48 hours of cancer chemotherapy, it is considered a Medicare Part B benefit
- If **not** being used within 48 hours of cancer chemotherapy, it is considered a Medicare Part D benefit
- Authorization of ondansetron is limited to:
 - 90 tablets per 30 days
- Authorization of granisetron is limited to:
 - 20 tablets per 30 days
- Authorization of Anzemet is limited to:
 - 3 tablet per 30 days
- Authorization of Emend is limited to:
 - 6 capsules per 30 days

Please Complete the Following Information:

Drug is being used within 48 hours of cancer chemotherapy:

- Yes – Medicare Part B benefit
 No – Medicare Part D benefit

Quantity requested is within limits as described above:

- Yes
 No – Rationale for use: _____

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

Please fax this request to: (877)974-4411 toll free or (616)942-8206
YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX