

Pharmacy Prior Authorization Form

Last Reviewed: July 08

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)

Member Name: _____ Member #: _____ - _____

DOB: _____ Sex: _____ Provider Phone: _____

Provider Name: _____ Provider Fax: _____

Provider Office Contact Name: _____ Date: _____

Drug (Choose one): Anzemet IV Aloxi IV

Duration: _____ weeks

Note: Evidence suggests similar efficacy among all 5-HT3 agents. Use of Anzemet, Kytril 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

For Internal Use Only

Original Date of Req: _____ Non-Urgent: ___ Urgent: ___ Retro: ___ Method: Phone ___ Fax ___ Ltr ___ Coord. Initial ___
Approved: ___ Denied: ___ Letter Type: Denial ___ 48 hr ___ Off-Label Use ___ Verbal: Y ___ N ___ Inquiry number: _____
Product: HMO ___ PPO ___ ASO ___ POS ___ Caid ___ MIChild ___ Mcare ___ McarePlus ___ McareRX ___ McareValue ___ EGMcare ___
Formulary (11/0030/R0) _____ Non-Formulary (11/0032/R0) _____
Dte Addt Info Req _____ by: Phone ___ Fax ___ Dte 48/OL Ltr sent: _____ Dte 2nd 48/OL Ltr Sent (Caid only) _____
Date All Info Recvd _____ Date of Decision to Deny: _____ RPh Initials: _____
Notified: _____ of Denial on: _____ by: Ph ___ Fax ___