

Pharmacy Prior Authorization Form

Last Reviewed: Nov. 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

Kytril and Zofran

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:

Kytril : 1 mg tabs 1 mg/5 ml soln

Zofran: 4 mg tabs 8 mg tabs 25 mg tabs 4 mg ODT 8 mg ODT 40 mg 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
- Documented therapeutic trial of all formulary alternatives such as: ondansetron, granisetron
- Authorization of Kytril and Zofran is limited to:
 - 20 tablets per 30 days
 - 100 mls 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: _____

Documented therapeutic trial of formulary alternatives:

- Yes
 Ondansetron Date of trial: _____
 Granisetron Date of trial: _____
 No – Rationale for use: _____

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

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YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX