

Pharmacy

PRIOR AUTHORIZATION FORM

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

Granisetron

URGENT (life threatening)

Non-Urgent (standard review)

A claim involving "urgent care" applies when the standard review time will seriously jeopardize the life or health of the member, or subject the member to severe pain that cannot be managed without the care or treatment requested in the subject of this request. **Priority Health averages between 1 and 3 business days for our standard review response time.**

Member Information

Member Name:	Member No.:
DOB:	Gender:
Member's PCP:	

Provider Information

Provider Name:	
Office Contact Name:	Provider Phone:
Provider NPI:	Provider Fax:
Provider Address:	

Provider Signature

Date

PRODUCT INFORMATION

granisetron

1mg Tab

1mg/mL Soln

Dosing Frequency: _____

Start Date: _____

PRECERTIFICATION REQUIREMENTS

PRIORITY HEALTH PRECERTIFICATION REQUIREMENTS

Authorization for granisetron requires the following information to certify:

Patient must have met the following requirements:

- Drug is being used for a medically accepted indication approved by CMS (Centers for Medicare and Medicaid Services)

PRIORITY HEALTH PRECERTIFICATION DOCUMENTATION

Authorization for granisetron requires the following information to certify:

A. Will this medication be administered within 48 hours of cancer chemotherapy?

- i. Yes (covered under Part B)
- ii. No (may be covered under Part D)

B. What is the patient's diagnosis?

- i. Chemotherapy-induced nausea and vomiting
- ii. Postoperative nausea and vomiting
- iii. Radiation-induced nausea and vomiting
- iv. Other: _____

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