

Pharmacy

PRIOR AUTHORIZATION FORM

Last Reviewed: January 2012

Last Updated: November 2010

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

Ondansetron

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

ondansetron
 4mg Tab
 4mg ODT
 Dosing Frequency: _____
 8mg Tab
 8mg ODT
 24mg Tab
 4mg/5mL Soln
 Start Date: _____

PRECERTIFICATION REQUIREMENTS

PRIORITY HEALTH PRECERTIFICATION REQUIREMENTS

Authorization for ondansetron 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 ondansetron 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. Pediatric gastroenteritis
- iii. Postoperative nausea and vomiting
- iv. Radiation-induced nausea and vomiting
- v. Other: _____

Rationale for use: _____

C. This drug is subject to a quantity limit of 90 tablets or 100 mL every 30 days. If a larger quantity is needed, please check off any of the following statements that apply:

- The number of doses available under a dose restriction for the prescription drug:
 - has been ineffective in the treatment of the enrollee's disease or medical condition, or
 - based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance.
- None of the above apply

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

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YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX