

# 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

**Sancuso<sup>®</sup> (granisetron transdermal patch)**  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: Sancuso 3.1mg/24 hr patch

Dose: \_\_\_\_\_ Start date: \_\_\_\_\_

## Priority Health Precertification Requirements:

Authorization of Sancuso requires all of the following:

- At least 18 years of age
- Prevention of nausea and vomiting in patients receiving moderately and/or highly emetogenic chemotherapy
- Documented intolerability to oral or IV antiemetic therapy

Criteria:

- Patient is at least 18 years of age
- Patient is undergoing moderately &/or highly emetogenic chemotherapy
- Patient has documented intolerability to oral or IV antiemetic therapy  
If not, please provide rationale for use: \_\_\_\_\_

---

**FOR MEDICARE ONLY**

---

**If none of the above precertification criteria is applicable to this member, please check off which, if any, of the following apply:**

1.  All covered Part D drugs on any tier of a plan's formulary would not be as effective for the enrollee as the non-formulary drug, and/or would have adverse effects
2.  The number of doses available under a dose restriction for the prescription drug:
  - a.  Has been ineffective in the treatment of the enrollee's disease or medical condition, or
  - b.  Based on 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.
3.  The prescription drug alternative(s) listed on the formulary or required to be used in accordance with step therapy requirements:
  - a.  Has been ineffective in the treatment of the enrollee's disease or medical condition, or
  - b.  Based on 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.
  - c.  Has caused or, based on sound clinical evidence and medical and scientific evidence, is likely to cause an adverse reaction or other harm to the enrollee.
4.  None of the above apply

**\*\*If you selected 1, 2, or 3 above, supporting evidence/documentation is required for review. If no supporting evidence/documentation is provided, this request will not be approved.**

**\*\*\* 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**