PriorityHealth

Priority Health Medicare prior authorization form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☒ **Medicare Part B** ☒ **Medicare Part D**
This request is: ☐ **Expedited request** ☐ **Standard request**

Your request will be expedited if you haven't gotten the prescription and Priority Health Medicare determines, or your prescriber tells us, that your life or health may be at risk by waiting.

Granisetron (oral)

Member

Last Name: ______________________ First Name: ______________________
ID #: ______________________ DOB: ______________ Gender: ______________
Primary Care Physician: ______________________

Requesting Provider: ______________________ Prov. Phone: ______________ Prov. Fax: ______________
Provider Address: ______________________
Provider NPI: ______________________ Contact Name: ______________________

Provider Signature: ______________________ Date: ______________

Product Information

☐ New request ☐ Continuation request

Drug product: ☐ Granisetron 1 mg tablet

Start date (or date of next dose): ______________
Date of last dose (if applicable): ______________
Dosing frequency: ______________

Coverage determination criteria

This drug requires prior authorization and may be covered differently under Medicare Part B (medical benefit) or D (prescription drug benefit) depending on the patient's circumstances. To determine which benefit the drug is covered under, Priority Health Medicare needs to know the use and setting of the drug.

1. **What condition is this drug being used for?**
   - ☐ Prevention of chemotherapy-induced nausea and vomiting
   - ☐ Prevention of postoperative nausea and vomiting
   - ☐ Prevention of radiation-induced nausea and vomiting
   - ☐ Other – the patient's condition is: ______________________

2. **Will granisetron be used as a full therapeutic replacement for the IV anti-emetic drug that would have otherwise been used?**
   - ☐ Yes
   - ☐ No

3. **Did you administer granisetron within 2 hours of administering the chemotherapy agent?**
   - ☐ Yes
   - ☐ No

4. **Will granisetron be continued beyond 48 hours from the time you administered the chemotherapy agent?**
   - ☐ Yes
   - ☐ No

All fields must be complete and legible for review. Your office will receive a response via fax.

No changes made since 09/2018
Last reviewed 09/2018

Additional information

Medicare Part B covers self-administered anti-emetic drugs necessary for the administration and absorption of the chemotherapeutic agent when a high likelihood of vomiting exists. The oral anti-emetic drug must be used under the following conditions for coverage under Medicare Part B:

- The oral drug is approved by the FDA for use as an anti-emetic
- The oral anti-emetic is administered by the treating physician or in accordance with a written order from the physician as part of a cancer chemotherapy regimen
- Oral anti-emetic drugs administered with a particular chemotherapy treatment are initiated within 2 hours of the administration of the chemotherapeutic agent and may be continued for a period not to exceed 48 hours from that time
- The oral anti-emetic drug is being used as a full therapeutic replacement for the intravenous anti-emetic drugs that would have otherwise been administered at the time of the chemotherapy treatment

When this drug is not covered under Medicare Part B, it is only covered under Medicare Part D when it is used for a medically accepted indication. A medically accepted indication is a use of the drug that is *either*:

- approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- *-- or –* supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information and the DRUGDEX Information System)

Priority Health Medicare exception request

Do you believe one or more of the prior authorization requirements should be waived? ☐ Yes ☐ No
If yes, you must provide a statement explaining the medical reason why the exception should be approved.

Would granisetron likely be the most effective option for this patient?
☐ No
☐ Yes, because:____

If the patient is currently using granisetron, would changing the patient's current regimen likely result in adverse effects for the patient?
☐ No
☐ Yes, because:____

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