

Prior Authorization Request Form for Anti-Nausea products- Emend/Kytril/Zofran

Member Information

Patient Name _____

Cardholder ID _____

Date of Birth _____

Address _____

City, State Zip _____

Phone Number _____

Provider Information

Provider Name _____

DEA Number _____

Address _____

City, State and Zip _____

Phone Number _____

FAX Number _____

Pharmacy Information

Pharmacy Name _____ Address _____ Phone _____

Criteria for Approval:

1. Anti-nausea medication requested: *Check one (please include strength and quantity requesting):*
 Emend _____ **Kytril** _____ **Zofran** _____
2. Has the patient been on the anti-nausea medication requested in the previous month? Yes No
3. Is the anti-nausea medication requested to be used to treat post-operative nausea/vomiting? Yes No
4. Is the anti-nausea medication requested to be used to treat chemotherapy induced nausea/vomiting as a replacement for an injectable antiemetic therapy? Yes No
5. Is the anti-nausea medication requested to be used as a full replacement of an intravenous administration within 48 hours of cancer treatment? Yes No
6. Is the anti-nausea medication requested to be used after 48 hours of cancer treatment? Yes No
7. Is Emend to be used in combination with a corticosteroid (i.e., dexamethasone) and a 5-HT3 antagonist (i.e., Kytril, Zofran)? Yes No
8. Does the patient require a quantity more than the following monthly limits of the anti-nausea medication requested? Yes No
 - Emend: 1 capsule of the 125 mg strength **X** the number of chemotherapy courses per month
2 capsules of the 80 mg strength **X** the number of chemotherapy courses per month
 - Kytril: 6 tablets of the 1mg strength
30ml of oral solution
1ml injectable
 - Zofran: 9 tablets/ODT of the 4 and 8mg strength
1 tablet of the 24mg strength
90ml of oral solution
50ml of the 32mg strength injectable
5ml of the 2mg strength injectable

Provider Signature _____ Date _____

Fax completed forms to (866) 284-4509.

For Office Use Only

Date/Time Received _____

Reference Number _____

Approved / Denied (Circle One) by _____ Date _____

Date/Time Returned to Provider _____

If you have any questions regarding this form, contact the Prior Authorization Department Toll Free at (866) 284-4492 or FAX Toll Free at (866) 284-4509.

FOX Rx Care Utilization Management
3375-I Capital Circle NE
Tallahassee, FL 32308

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