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 strenth 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.

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