

Fax completed form to: 1-866-868-0858
Questions, please call: 1-866-316-6049

GENERATIONS HEALTHCARE

Important Information About Prescription Drug Coverage

To: _____ From: _____

Fax: _____ Pages: _____

Re: Antiemetics: Prior Authorization Request Form: Please respond.

- Please complete the attached Antiemetics Prior Authorization Request Form
- To expedite the review process please complete all requested fields.
- Completed forms should be faxed to: 1-866-868-0858. It is not necessary to fax this cover page.

Please note: By signing the attached form you are certifying that the treatment requested is medically necessary. No contraindications are present and precautions have been considered. You will be supervising the patient's treatment. Supporting documentation is available in the patient's record. Signature on this form attests to the fact that the corresponding ICD-9 code has been documented in the patients chart and submitted on a CMS- 1500 form.

Information about this drug

Antiemetics

Oral antiemetics when used as a full therapeutic replacement for intravenous antiemetics for the prevention and treatment of Chemotherapy Induced Nausea and Vomiting (CINV) are covered under Medicare Part B.

You can make an expedited request by indicating this at the top of the attached form. If you request an expedited review, and sign the attached form, you certify that applying the 72 hour standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

Information on the attached form is protected health information and subject to all privacy and security regulations under HIPAA.

Prior Authorization Request Form

Fax completed form to 1-866-868-0858 Need help? Call 1-866-316-6049

Patient Information

Name _____
Member ID _____
Medicare ID _____
Date of birth _____ Sex: M / F
Address _____
City _____
State _____ ZIP _____
Phone _____
Nursing home resident? YES / NO
Home care patient? YES / NO

Prescriber and Pharmacy Information

Name _____
Specialty _____
DEA _____
NPI _____
Address _____
City _____
State _____ ZIP _____
Phone _____ Fax _____
Pharmacy name _____
NCPDP _____
NPI _____
Phone _____ Fax _____

All items below this line are for Physician Use Only

Information for Requested Drug

Strength: _____ Dosage form: _____ Qty per 30 days: _____ Drug is (circle one): Newly prescribed/Refill
Directions: _____ Diagnosis: _____ ICD-9 Code: _____

Standard Reviews will be completed in under 72 hours. An expedited review is available if you certify that a standard review timeframe will seriously jeopardize the health of your patient. To request an expedited review, simply indicate this at the top of this page.

Antiemetics Criteria

- Indicate antiemetic requested:
 Ondansetron Anzemet®
 Kytril® Zofran®
 Emend® Marinol®
 dexamethasone nabilone
 diphenhydramine prochlorperazine
 promethazine chlorpromazine
 trimethobenzamide perphenazine
 hydroxyzine pamoate
- Indicate route of administration requested:
 oral injection
- Specify dosing instructions, duration, & quantity requested:

- Please specify antiemetic diagnosis:
(Nausea with or without vomiting ICD-9: 787)
 Chemotherapy Induced Nausea and Vomiting (CINV) prescribed as a full replacement for IV anti-emetic drugs within 48 hrs of chemotherapy (within 24 hrs of chemotherapy if Anzemet or Kytril).
 Chemotherapy Induced Nausea and Vomiting (CINV) NOT prescribed as a full replacement for IV anti-emetic drugs within 48 hrs of chemotherapy (within 24 hrs of chemotherapy if Anzemet or Kytril).
- Other _____
- Please specify the diagnosis code(s) supporting the necessity for the requested agent. This question must be completed.
 ICD-9: _____
- List all other antiemetics the patient is receiving and route of administration:

- Describe route and location of chemotherapy administration:
 IV PO Home
 Other

Medical justification: (Attach additional page if necessary): _____

Prescriber's signature: _____ Date: _____