

Fax completed form to: 1-866-868-0858

Questions, please call: 1-866-316-6049

**TODAY'S OPTIONS®**

**Important Information About Prescription Drug Coverage**

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To: \_\_\_\_\_ From: \_\_\_\_\_

Fax: \_\_\_\_\_ Pages: \_\_\_\_\_

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

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- 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

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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.**

MemberHealth, LLC, PO Box 391197, Solon OH 44139-3911

Last Updated: 01/21/2008

M0018\_TO\_PaTemp\_1107 CMS 11/28/07 H3333/H5421

# Prior Authorization Request Form

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

**TODAY'S OPTIONS®**

## 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:
 

<input type="checkbox"/> Ondansetron	<input type="checkbox"/> Anzemet®
<input type="checkbox"/> Kytril®	<input type="checkbox"/> Zofran®
<input type="checkbox"/> Emend®	<input type="checkbox"/> Marinol®
<input type="checkbox"/> dexamethasone	<input type="checkbox"/> nabilone
<input type="checkbox"/> diphenhydramine	<input type="checkbox"/> prochlorperazine
<input type="checkbox"/> promethazine	<input type="checkbox"/> chlorpromazine
<input type="checkbox"/> trimethobenzamide	<input type="checkbox"/> perphenazine
<input type="checkbox"/> hydroxyzine pamoate	
- Indicate route of administration requested:
 

<input type="checkbox"/> oral	<input type="checkbox"/> injection
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- Specify dosing instructions, duration, & quantity requested:
 

<input type="checkbox"/> _____
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- Please specify antiemetic diagnosis: (Nausea with or without vomiting ICD-9: 787)
 

<input type="checkbox"/> 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).
<input type="checkbox"/> 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.
 

<input type="checkbox"/> ICD-9: _____
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- List all other antiemetics the patient is receiving and route of administration:
 

<input type="checkbox"/> _____
<input type="checkbox"/> _____
<input type="checkbox"/> _____
<input type="checkbox"/> _____
- Describe route and location of chemotherapy administration:
 

<input type="checkbox"/> IV	<input type="checkbox"/> PO	<input type="checkbox"/> Home
<input type="checkbox"/> Other		

Medical justification: (Attach additional page if necessary): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Prescriber's signature: \_\_\_\_\_ Date: \_\_\_\_\_