PRIOR AUTHORIZATION REQUEST FORM

Medicare - Oral Anti-Emetics (B vs. D)

Phone: 800-728-7947 Fax back to: 866-880-4532

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. Please note, any information left blank or illegible may delay the review process.

Patient Name:	**Prescriber Name:** **Supervising Physician:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Please specify the oral anti-emetic drug that is being requested?

- ☐ Zofran (ondansetron)
- ☐ Kytril (granisetron)
- ☐ Emend (aprepitant)
- ☐ Anzemet (dolasetron)
- ☐ Varubi (rolapitant)
- ☐ Akynzeo (netupitant and palonosetron)

Q2. Is the ORAL ANTI-EMETIC drug being used to treat chemotherapy-induced nausea and vomiting as a FULL THERAPEUTIC REPLACEMENT for an IV anti-emetic drug that would otherwise have been administered at the time of chemotherapy treatment?

☐ Yes ☐ No

Q3. If the request is for Emend (aprepitant) or Varubi (rolapitant), is the requested NK-1 antagonists being used in as part of a 3-drug regimen which includes dexamethasone and a 5-HT3 antagonist (e.g. granisetron, ondansetron,

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dolasetron)?

☐ Yes ☐ No

Q4. If the request is for Akynzeo (netupitant and palonosetron), is Akynzeo being used in combination with dexamethasone?

☐ Yes ☐ No

Q5. Is the CHEMOtherapy agent being administered via IV route?

☐ Yes ☐ No

Q6. Is the CHEMOtherapy agent being administered in the patient's home?

☐ Yes ☐ No

Q7. If the request is for ANZEMET (dolasetron), VARUBI (rolpitant), or Akynzeo (netupitant and palonosetron), please list all FORMULARY ALTERNATIVES the patient has tried, or provide justification as to why formulary alternatives would not be appropriate.

Q8. Is the patient receiving one of the following anti-cancer chemotherapeutic agents: Alemtuzumab, Azacitidine, Bendamustin, Carboplatin, Carmustine, Cisplatin, Clofarabine, Cyclophosphamide, Cytarabine, Dacarbazine, Daunorubicin, Doxorubicin, Epirubicin, Idarubicin, Ifosfamide, Irinotecan, Lomustine, Mechlorethamine, Oxaliplatin, Streptozocin

☐ Yes ☐ No

Q9. Additional Comments

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Prescriber Signature

Date

□ Expedited/Urgent - By checking this box and signing above, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function