Prior Authorization Form

Aloxi, Anzemet, Kytril, Zofran Post Limit

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS/Caremark at **1-888-836-0730**.
When conditions are met, we will authorize the coverage of Aloxi, Anzemet, Kytril, Zofran Post Limit.

Drug Name
(specify drug) _____

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician
Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Please circle the appropriate answer for each question.

1. Does the patient require more than the following limits? Y N

   Aloxi 0.25 mg/5 mL or 0.075 mg/1.5 mL Injection - 5 mL per 15 days / Anzemet 50 mg and 100 mg Tablets - 3 tablets per 15 days / Anzemet 100 mg/5 mL or 12.5 mg/0.625 mL Injection - 5 mL per 30 days / Granisetron 1 mg Tablets - 6 tablets per 15 days / Granisetron 0.1 mg/mL or 1 mg/mL Injection - 1 mL per 15 days / Granisol 1 mg/5 mL Oral Solution - 30 mL per 15 days / Sancuso 3.1 mg/24 hour Patches - 2 patches per 15 days / Zofran 4 mg and 8 mg Tablets/ODT - 12 tablets per 15 days / Ondansetron 24 mg Tablet - 1 tablet per 15 days / Zofran 4 mg/5 mL Oral Solution - 100 mL per 15 days / Ondansetron 32 mg/50 mL Injection - 50 mL per 15 days / Zofran 2 mg/mL Injection - 10 mL per 15 days / Zuplenz 4 mg and 8 mg Oral Soluble Film - 12 films per 15 days

   [If the answer to this question is no, a prior authorization is not required. These quantities are available without a prior authorization.]

2. Is Anzemet Injection the medication being requested? Y N

   [If the answer to this question is yes, then no further questions are required.]

3. Is generic ondansetron or Zofran the medication being requested? Y N

   [If the answer to this question is no, then skip to question 5.]

4.	Does the patient have a diagnosis of Hyperemesis Gravidarum?	Y N
	[If the answer to this question is yes, then skip to question 7.]	
5.	Is the patient receiving moderate to highly emetogenic chemotherapy?	Y N
	[If the answer to this question is yes, then skip to question 10.]	
6.	Is the patient receiving radiation therapy?	Y N
	[If the answer to this question is yes, then skip to question 10.]	
7.	Has the patient experienced an inadequate treatment response to two of the following medications: vitamin B6, doxylamine, promethazine (Phenergan), trimethobenzamide (Tigan) or metoclopramide (Reglan)?	Y N
	[If the answer to this question is yes, then skip to question 9.]	
8.	Is the patient intolerant to or had a confirmed adverse event with two of the following medications: vitamin B6, doxylamine, promethazine (Phenergan), trimethobenzamide (Tigan) or metoclopramide (Reglan)?	Y N
	[If the answer to this question is no, then no further questions are required.]	
9.	Is generic ondansetron or Zofran being requested because the patient has a documented risk for hospitalization for rehydration?	Y N
	[No further questions are required.]	
10.	How many days per month does the patient receive nausea/emesis-inducing therapy?	Y N _____

Comments: _____

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature and Date