Prior Authorization Form

Antiemetics 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 **1-855-245-2134**.
Please contact CVS/Caremark at **1-855-582-2022** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Antiemetics Post Limit (HMF).

Drug Name
(specify drug) _____

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

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:** _____

Comments: _____

Please circle the appropriate answer for each question.

1.	Is this request for Zofran or ondansetron?	Y N
	[If no, then skip to question 4.]	
2.	Is the patient a pregnant female with the diagnosis of Hyperemesis Gravidarum and a documented risk for hospitalization?	Y N
	[If no, then skip to question 4.]	
3.	Has the patient experienced an inadequate treatment response, intolerance, or contraindication to two of the following medications: vitamin B6, doxylamine, promethazine (Phenergan), trimethobenzamide (Tigan) or metoclopramide (Reglan)?	Y N

	[No further questions.]
4.	Is the patient receiving radiation therapy or moderate to highly emetogenic chemotherapy? Y N

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

Prescriber (Or Authorized) Signature and Date