



PRIOR AUTHORIZATION REQUEST FORM

Brand Antiemetics for Chemotherapy Induced Nausea and Vomiting

Akynzeo® (netupitant and palonosetron) Capsules,
Sancuso® (granisetron) patch, Sustol® (granisetron) subcutaneous injection, Varubi® (rolapitant) tablets,
Zuplenz® (ondansetron) film

For authorization, please answer each question and fax this form PLUS chart notes back to Real Rx at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance 385-425-5094.

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Form with fields: Date, Member Name, ID#, DOB, Gender, Physician, Office Phone, Office Fax, Office Contact, Height/Weight, HCPCS Code

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested:

- NK1 antagonist: [] Varubi® (rolapitant) tablets
5-HT3 antagonists: [] Sancuso® (granisetron) patch, [] Sustol® (granisetron) SQ injection, [] Zuplenz® (ondansetron) film
5-HT3/NK1 combination: [] Akynzeo® (netupitant/palonosetron) capsules

Dosing/Frequency: _____

Table with 4 columns: Questions, Yes, No, Comments/Notes. Rows for AKYNZEO®, SANCUSO®, and SUSTOL® with specific questions and checkboxes.

2. Has the member tried and failed all of the following: <ul style="list-style-type: none"> • Ondansetron • Granisetron • Sancuso® patch 	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
VARUBI®			
1. Is this request for prevention of nausea and vomiting associated with moderately to highly emetogenic intravenous chemotherapy regimens?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has the member tried and failed aprepitant and fosaprepitant?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
ZUPLENZ®			
1. Is this request for prevention of nausea and vomiting associated with moderately to highly emetogenic intravenous chemotherapy regimens?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has the member tried and failed all of the following: <ul style="list-style-type: none"> • Ondansetron ODT • Granisetron 	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician Signature:			

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy PHARM- 006
 Origination Date: 06/22/2018
 Reviewed/Revised Date: 07/22/2022
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