HEALTHY U CHIP

PRIOR AUTHORIZATION REQUEST FORM
AKYNZEO® IV

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U CHIP Prior Authorization Department at 801-213-1547.

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

If you have medical pharmacy prior authorization questions, please call for assistance: 833-981-0212

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

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: ☐ Akynzeo® (fosaprepitant/palonosetron) IV

Dosing/Frequency:____

Questions	Yes	No	Comments/Notes
1. Is this request for prevention of acute and delayed nausea and vomiting associated with initial and repeat courses of highly emetogenic intravenous chemotherapy?	☐	☐	**Please provide documentation**
2. Is the request for prevention of acute and delayed nausea and vomiting associated with initial and repeat courses of moderately emetogenic intravenous chemotherapy? **Documentation must show previous treatment failure, intolerance, contraindication, to a steroid + 5HT3 RA + olanzapine OR clinical reasoning as to why NK-1 RA is needed.**	☐	☐	**Please provide documentation**
3. Has the member tried and failed aprepitant and fosaprepitant in combination with palonosetron?	☐	☐	**Please provide documentation**
4. Is the request for the prevention of nausea and vomiting associated with anthracycline plus cyclophosphamide (AC) chemotherapy? **Documentation must show medical necessity.**	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Does documentation show the therapy was effective with a positive clinical response to therapy?	☐	☐	**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:

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Policy: PHARM-CHIP-M028
Origination Date: 07/01/2024
Reviewed/Revised Date:
Next Review Date:
Current Effective Date: 07/01/2024

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