HEALTHY U CHIP

PRIOR AUTHORIZATION REQUEST FORM

Brand Antiemetics for Chemotherapy Induced Nausea and Vomiting

Akynzeo® Capsules, Sancuso® patch, Sustol® subcutaneous injection, Varubi® tablets, Zuplenz®

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

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:_____

Questions	Yes	No	Comments/Notes
AKYNZEO®			
1. Is this request for prevention of nausea and vomiting associated with moderately to highly emetogenic intravenous chemotherapy regimens?	☐	☐	
2. Has the member tried and failed aprepitant or fosaprepitant in combination with palonosetron?	☐	☐	**Please provide documentation**
SANCUSO®			
1. Is this request for prevention of nausea and vomiting associated with moderately to highly emetogenic intravenous chemotherapy regimens?	☐	☐	
2. Has the member tried and failed all of the following: • ondansetron • granisetron	☐	☐	**Please provide documentation**
SUSTOL®			
1. Is this request for prevention of nausea and vomiting associated with moderately to highly emetogenic intravenous chemotherapy regimens?	☐	☐	
2. Has the member tried and failed all of the following: • Ondansetron • Granisetron	☐	☐	**Please provide documentation**

• Sancuso® patch			
VARUBI®			
1. Is this request for prevention of nausea and vomiting associated with moderately to highly emetogenic intravenous chemotherapy regimens?	☐	☐	
2. Has the member tried and failed aprepitant and fosaprepitant?	☐	☐	**Please provide documentation**
ZUPLENZ®			
1. Is this request for prevention of nausea and vomiting associated with moderately to highly emetogenic intravenous chemotherapy regimens?	☐	☐	
2. Has the member tried and failed all of the following: • Ondansetron ODT • Granisetron	☐	☐	**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-CHIP- 006
Origination Date: 07/01/2024
Reviewed/Revised Date: 08/29/2024
Next Review Date: 08/29/2025
Current Effective Date: 09/01/2024