

ANTIEMETIC DRUGS
Preauthorization Request
 (Preauthorization is not a guarantee of payment)

SECTION I – General Information

Today's Date: / /	<input type="checkbox"/> New request
Fax completed form to: <u>1-866-805-4150</u> toll free	<input type="checkbox"/> Re-Authorization

Level of Urgency:

Standard Request (Routine Care)—Care/treatment that is not emergent, urgent, or preventive in nature.

Expedited Request—Care/treatment that is emergent or the application of the timeframe for making Standard/Routine or nonlife-threatening care determinations:

- Could seriously jeopardize the life, health, or safety of the member or others, due to the member's psychological state, or
- In the opinion of the practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.

For Expedited Request, Please Explain:

SECTION II – Member Information

Patients Name:	Member ID:	Patient Information: DOB: __/__/__ Sex: Age: Weight: <input type="checkbox"/> lbs. <input type="checkbox"/> Kg Will the patient self-administer the requested medication? <input type="checkbox"/> Yes <input type="checkbox"/> No
Patients Address:	Is CBC primary payer: <input type="checkbox"/> Yes <input type="checkbox"/> No	

Plan Type:

PPO POS KHPC CHIP (aka Capital Cares 4Kids)
 Traditional Comprehensive Special Care Other* _____

**NOTE: For all Medicare Advantage products, please contact Prime Therapeutics at <https://www.covermy meds.com/main> or via phone at 1-866-260-0452.*

SECTION III – Provider Information Required

Requesting Provider Name: Address:	Requesting Provider CBC # _____ NPI # _____
Telephone #:	Secure Fax #:
Office Contact Name:	Office Contact Telephone #:

Is the Rendering/Service provider different? <input type="checkbox"/> No <input type="checkbox"/> Yes – Complete rendering provider information below.	
Rendering Provider Name: Address: Telephone:	Rendering Provider CBC # _____ NPI # _____
Site of Service: <input type="checkbox"/> MD Office <input type="checkbox"/> Home Health <input type="checkbox"/> Non-hospital affiliated, outpatient infusion center <input type="checkbox"/> Hospital affiliated, outpatient infusion center <input type="checkbox"/> Other: Specify _____ <i>*Please refer to MP 3.016 for Site of Service requirements.</i>	Check all that apply and include all applicable documentation: <input type="checkbox"/> There are contraindications to a less intensive site of care. <input type="checkbox"/> A less intensive site of care is not appropriate for the patient's condition. <input type="checkbox"/> Patient is being treated with a drug that cannot be administered in a less intensive site of care concurrently. <input type="checkbox"/> Less intensive site of care is not available. <i>*Please include all applicable documentation.</i>
SECTION IV – Preauthorization Requirements and Clinical Criteria	
Prescribed in consultation with a specialist? <input type="checkbox"/> Yes Specialty: _____ <input type="checkbox"/> No	
<input type="checkbox"/> New to therapy <input type="checkbox"/> Continuing therapy*: Initial start __/__/__ <input type="checkbox"/> Reinitiating therapy: Last treatment __/__/__ <i>*Please include documentation for changes in dose.</i>	Route of Administration: <input type="checkbox"/> Intravenous (IV) <input type="checkbox"/> Injection (Sub Q or IM) <input type="checkbox"/> Oral (PO) or Enteral <input type="checkbox"/> Other: Specify _____
HCPC Code(s):	Diagnosis Code(s):
Medication requested:	Indication:
Does the patient have late stage metastatic disease? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>For patients with late stage metastatic disease (Stage IV), please refer to MP 2.373 Step Therapy Treatment in Cancer, Including Treatments for Stage Four, Advanced Metastatic Cancer and Severe Related Health Conditions for additional guidance.</i>	
Type of drug requested: <input type="checkbox"/> Brand name <input type="checkbox"/> Generic <input type="checkbox"/> Biosimilar <input type="checkbox"/> Other: Specify _____	
Initial start date of therapy: __/__/__	Anticipated date of next administration: __/__/__
Dosing period for request: Start Date: __/__/__ End Date: __/__/__	Dosing Information: Dose: Strength: Frequency: Quantity requested per month:
Attach documentation demonstrating the medical necessity of the requested drug. Please list all reasons for selecting the requested medication, strength, dosing schedule, and quantity over alternatives (e.g., contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max.)	
Has the patient had medical testing completed for use of this drug? (labs, imaging) <input type="checkbox"/> Yes <input type="checkbox"/> No Results: _____	
Is drug being requested for an "off label" indication ? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please see Medical Policy 2.103 and include any applicable documentation.	

<p>Please list any previous medications that were tried and failed. Include reason for discontinuation (intolerance, hypersensitivity, inadequate response etc.). Please attach documentation.</p> <p>Drug(s) and strength: Documentation of failure:</p>	
<p><i>Prior authorization is not a guarantee of payment; benefits and eligibility will apply at the time of claim adjudication.</i></p>	
<p>Antiemetic:</p> <p><input type="checkbox"/> Palonosetron (palonosetron hydrochloride)</p> <p>Will the patient be receiving one of the following (choose ONE):</p> <p><input type="checkbox"/> High risk emetogenic regimen <input type="checkbox"/> Medium risk emetogenic regimen <input type="checkbox"/> Low or minimal risk emetogenic regimen <input type="checkbox"/> Other: Specify _____</p> <p>*Include all applicable documentation for request. _____</p>	
<p>Please use a separate form for each drug.</p> <p>To fill out form type or write using blue or black ink</p> <p>Please fax this form to: <u>1-866-805-4150</u></p> <p>Telephone: 1-800-471-2242</p>	<p>CONFIDENTIALITY NOTICE: This communication is intended only for the use of the individual entity to which it is addressed, and may contain information that is privileged or confidential. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please notify the sender immediately by telephone at 1-800-471-2242. Thank you for your cooperation.</p>
<p>Prior authorization is not a guarantee of payment; benefits and eligibility will apply at the time of claim adjudication.</p>	

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