PRIOR AUTHORIZATION REQUEST FORM
MEDICARE PART D
Oral Anti-emetics

MVP HEALTH CARE℠

DATE OF REQUEST:_____

MEMBER INFORMATION

NAME _____

ID # _____

BIRTHDATE _____

☑ PLEASE NOTE: By signing this form, you are attesting to the accuracy of the information provided, and that medical record documentation is available if requested.

PROVIDER INFORMATION

NAME _____

NPI # _____

ADDRESS _____

_____

PHONE #_____FAX #_____

CONTACT NAME _____

PROVIDER SIGNATURE _____

Drug Requested: ☐ Anzemet® ☐ Kytril® ☐ Zofran® ☐ Emend®

Check one: □ Initial Request □ Extension Request □ Other:_____
□ Intravenous □ Oral

Dose/frequency/quantity: _____

Diagnosis_____ **ICD-9 code** _____

If the quantity requested is greater than quantity limits, additional information will be requested.

Is above requested anti-emetic agent being used as part of a chemotherapeutic regimen?	❑ YES	❑ NO
Was an IV dose of any anti-emetic agent given on day of chemotherapy at infusion center/MD office?	❑ YES	❑ NO
Was an oral anti-emetic agent administered on day of chemotherapy at the infusion center/MD office?	❑ YES	❑ NO
Will IV med be administered in the home? If yes, please provide documentation to support medical necessity vs. oral agent(s)	❑ YES	❑ NO
For Emend: will a 5-HT3 antagonist **AND** dexamethasone be used in combination with Emend?	☐ YES	☐ NO

- Rxs for ≤ 48 hrs for **oral** therapy and no IV anti-emetic used, are covered under Part B for the following: dexamethasone*, dronabinol*, ondansetron, prochlorperazine*, promethazine*.
- Rxs for ≤ 24 hrs for **oral** therapy and no IV anti-emetic used, are covered under Part B for the following: granisetron or dolasetron.
- If any IV 5HT3 agent was used in the office, the drugs listed above are considered a Part D benefit and subject to the Rx benefit.
- All Rxs written for > than the timeframes listed above will be designated Part D drugs and subject to the Rx benefit.
- Aprepitant will be covered under part B when used with a 5-HT3 antagonist and dexamethasone and used as full replacement to IV drugs. If the combination is not full replacement for IV antiemetic therapy (or the entire combination was not prescribed), coverage will be dependent upon the Rx benefit.

**Drugs identified with (*), only require prior authorization for Medicare members who do not have a Rx benefit*
Refer to Medicare Part B vs Part D and Quantity Limits policies for additional prior authorization criteria & documentation requirements

FAX THIS REQUEST TO:
Medicare Part D **1-800-401-0915**
(*Preferred Gold, GoldAnywhere, GoldValue, USA Care, MVP RxCare)*