IOWA Health and Human Services

Request for Prior Authorization
ANTIEMETIC-5HT3 RECEPTOR ANTAGONISTS/ SUBSTANCE P NEUROKININ PRODUCTS

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone

Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.

Pharmacy NPI	Pharmacy fax	NDC

Prior authorization is required for preferred Antiemetic-5HT3 Receptor Antagonists/Substance P Neurokinin medications for quantities exceeding the dosage limits provided in parentheses. Payment for Antiemetic-5HT3 Receptor Agonists/Substance P Neurokinin Agents beyond this limit will be considered on an individual basis after review of submitted documentation.
Prior authorization will be required for all non-preferred Antiemetic-5HT3 Receptor Antagonists/ Substance P Neurokinin medications beginning the first day of therapy. Payment for non-preferred medications will be authorized only for cases in which there is documentation of previous trial(s) and therapy failure with a preferred agent in this class. Note: Aprepitant (Emend®) will only be payable when used in combination with other antiemetic agents (5-HT3 medication and dexamethasone) for patients receiving highly emetogenic cancer chemotherapy.

Preferred
- ☐ Emend 80mg capsules (8)
- ☐ Emend 125mg capsules (4)
- ☐ Ondansetron 4mg tablets (60)
- ☐ Ondansetron 8mg tablets (60)
- ☐ Ondansetron 2mg/mL (4 – 20mL vials)
- ☐ Ondansetron 2mg/mL (8 – 2mL vials)
- ☐ Ondansetron ODT 4mg tablets (60)
- ☐ Ondansetron ODT 8mg tablets (60)
- ☐ Ondansetron oral solution 4mg/5mL (50mL/month)

Non Preferred
- ☐ Akynzeo (2)
- ☐ Anzemet 50mg & 100mg tablets (5)
- ☐ Anzemet 100mg/5ml (4 vials)
- ☐ Anzemet 12.5mg/0.625ml (8 ampules)
- ☐ Aprepitant
- ☐ Emend Oral Suspension
- ☐ Granisetron 1mg tablets (8)
- ☐ Sancuso patch

Strength _____ **Dosage Instructions** _____ **Quantity** _____ **Days Supply** _____

Diagnosis: _____

Medical reasoning for therapy exceeding dosage limits: _____

_____

Reason for use of Non-Preferred drug requiring prior approval: _____
Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission

IMPORTANT NOTE: *In evaluating requests for prior authorization, the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary, by contact with the county Department of Health and Human Services, that the member continues to be eligible for Medicaid.*