https://providers.amerigroup.com

CONTAINS CONFIDENTIAL PATIENT INFORMATION

ANTIEMETIC-5HT3 RECEPTOR ANTAGONISTS/ SUBSTANCE P NEUROKININ PRODUCTS

Prior Authorization of Benefits (PAB) Form

Complete form in its entirety and fax to:
Prior Authorization of Benefits Center at 1-844-512-9004
Provider Help Desk 1-800-454-3730

1. PATIENT INFORMATION

Patient Name: _____

Patient ID #: _____

Patient DOB: _____

Date of Rx: _____

Patient Phone #: _____

Patient Email Address: _____

2. PHYSICIAN INFORMATION

Prescribing Physician: _____

Physician Address: _____

Physician Phone #: _____

Physician Fax #: _____

Physician Specialty: _____

Physician DEA: _____

Physician NPI #: _____

Physician Email Address: _____

3. MEDICATION	4. STRENGTH	5. DIRECTIONS	6. QUANTITY PER 30 DAYS
	_____	_____	Specify: _____

7. DIAGNOSIS: _____

8. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY

NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.

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 ReceptorAntagonists/ 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

- ☐ 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)
- ☐ Akynzeo (2)
- ☐ Aloxi 0.25mg/5mL (4 vials)
- ☐ Anzemet 50mg & 100mg tablets (5)
- ☐ Anzemet 100mg/5mL (4 vials)
- ☐ Anzemet 12.5mg/0.625mL (8 ampules)
- ☐ Aprepitant
- ☐ Granisetron 1mg tablets (8)
- ☐ Granisetron 1mg/mL (8 vials)
- ☐ Granisetron 4mg/4mL (2 vials)
- ☐ Ondansetron 4mg/5mL oral solution (50mL/month)
- ☐ Sancuso Patch
- ☐ Varubi
- ☐ Zuplenz

CONTAINS CONFIDENTIAL PATIENT INFORMATION

ANTIEMETIC-5HT3 RECEPTOR ANTAGONISTS/ SUBSTANCE P NEUROKININ PRODUCTS

Prior Authorization of Benefits (PAB) Form

Complete form in its entirety and fax to:
Prior Authorization of Benefits Center at 1-844-512-9004

PATIENT NAME: _____ **PATIENT ID #:** _____

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.

9. PHYSICIAN SIGNATURE

_____ _____
Prescriber or Authorized Signature Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.
Note: Payment is subject to member eligibility. Authorization does not guarantee payment.