

OPTIMA FAMILY CARE MEDALLION 4.0

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; fax to 1-800-750-9692. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. Incomplete forms will delay the authorization process.

Drug Requested: **ANTIEMETIC/ANTIVERTIGO**

(MEDICAID)

DRUG INFORMATION: Check **all** that apply and complete information or authorization process will be delayed.

PREFERRED Medications

<input type="checkbox"/> dronabinol (Requires PA)	<input type="checkbox"/> ondansetron ODT/tab – NO PA required	<input type="checkbox"/> meclizine – NO PA required
<input type="checkbox"/> metoclopramide tab/sol – NO PA required	<input type="checkbox"/> ondansetron tab & ODT – NO PA required	<input type="checkbox"/> prochlorperazine tab/syrup – NO PA required
<input type="checkbox"/> promethazine – NO PA required		

All Non-Preferred Medications (requires PA)

<input type="checkbox"/> Anzemet®	<input type="checkbox"/> aprepitant capsule/pack	<input type="checkbox"/> Akynzeo®	<input type="checkbox"/> Antivert®
<input type="checkbox"/> Compazine® sup/tab	<input type="checkbox"/> Compro®	<input type="checkbox"/> Cesamet®	<input type="checkbox"/> Diclegis®
<input type="checkbox"/> dimenhydrinate	<input type="checkbox"/> Emend® Bi Pak	<input type="checkbox"/> Emend® cap	<input type="checkbox"/> Emend® Tri-fold pack
<input type="checkbox"/> Emend® susp	<input type="checkbox"/> granisetron	<input type="checkbox"/> hydroxyzine	<input type="checkbox"/> Kytril®
<input type="checkbox"/> Marinol®	<input type="checkbox"/> Metozolv® ODT	<input type="checkbox"/> metoclopramide ODT	<input type="checkbox"/> ondansetron soln
<input type="checkbox"/> Phenergan®	<input type="checkbox"/> prochlorperazine sup	<input type="checkbox"/> promethazine	<input type="checkbox"/> Reglan®
<input type="checkbox"/> Sancuso® patch	<input type="checkbox"/> Tigan®	<input type="checkbox"/> Transderm-Scop®	<input type="checkbox"/> trimethobenzamide
<input type="checkbox"/> Varubi®	<input type="checkbox"/> Zofran® ODT/soln/tab	<input type="checkbox"/> Zuplenz® film	<input type="checkbox"/> Cinvanti™ IV

Drug Name/Form: _____ **Strength:** _____

Dosing Schedule/Frequency: _____ **Length of Therapy:** _____

DIAGNOSIS AND CLINICAL CRITERIA: Check box(es) below that apply to ensure authorization process will **NOT** be delayed.

1. Diagnosis of severe, chemotherapy induced nausea and vomiting Yes No
2. If diagnosis is AIDs-related wasting, member has tried and failed megestrol acetate oral suspension **OR** has a contraindication, intolerance, drug-drug interaction. Yes No N/A
3. Nausea or vomiting related to radiation therapy, moderate-to-highly emetogenic chemotherapy, or post-operative nausea and vomiting. Yes No
4. Member has tried and failed therapeutic does of, or has adverse effects or contraindications to two (2) different conventional antiemetics (e.g., promethazine, prochlorperazine, meclizine, metoclopramide, dexamethasone, etc.) Yes No
5. Hyperemesis (pregnancy-related nausea/vomiting) Yes No

Provide clinical evidence that the **Preferred** agent(s) **will not** provide adequate benefit **and** list pharmaceutical agents attempted and outcome: _____

(signature on next page)

Use of samples to initiate therapy **does not meet step-edit/preauthorization criteria.**

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

Patient Name: _____

Member Optima #: _____ Member Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

REVISED/UPDATED: 7/1/2018