OPTIMA HEALTH COMMUNITY CARE

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 1-800-319-5003. 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. If incomplete, authorization process will be delayed.

Preferred Medications	All Non-Preferred Medications (requires PA)
❑ dronabinol (Requires PA) ❑ ondansetron ODT/tab – NO PA required ❑ meclizine – NO PA required ❑ metoclopramide tab/sol – NO PA required ❑ ondansetron tab & ODT – NO PA required ❑ prochlorperazine tab/syrup – NO PA required ❑ promethazine – NO PA required	❑ Anzemet® ❑ apprepitant capsule/pack ❑ Akynzeo® ❑ Compazine® sup/tab ❑ Compro® ❑ Cesamet® ❑ Diclegis® ❑ dimenhydrinate ❑ Emend® Bi Pak ❑ Emend® cap ❑ Emend® Tri-fold pack ❑ Emend® susp ❑ granisetron ❑ hydroxyzine ❑ Kytril® ❑ Marinol® ❑ Metozolv® ODT ❑ metoclopramide ODT ❑ ondansetron soln ❑ Phenergan® ❑ prochlorperazine sup ❑ promethazine ❑ Reglan® ❑ Sancuso® patch ❑ Tigan® ❑ Transderm-Scop® ❑ trimethobenzamide ❑ Varubi® ❑ Zofran® ODT/soln/tab ❑ Zuplenz® film

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

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

DIAGNOSIS AND CLINICAL CRITERIA: Check box(es) below that apply or authorization process will 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
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: _____

_____

_____

****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: ~~6/30/2017; 7/17/2017;~~ **8/31/2017**