SENTARA COMMUNITY PLAN
(MEDICAID)

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. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

ANTIEMETIC/ANTIVERTIGO DRUGS

Drug Requested: (Check below the drug that applies)

PREFERRED MEDICATIONS (*PREFERRED Dronabinol and Diclegis Require Prior Authorization)**		
❑ **Diclegis®** (doxylamine succinate/vitamin B6) ***	❑ **ondansetron ODT/tab/soln (maximum quantity per fill=60)**	❑ **meclizine**
❑ **metoclopramide (tab/soln)**	❑ **Phenadoz® supp (AG) (members over 2 years of age)**	❑ **Prochlorperazine (tab/syrup)**
❑ **promethazine (AG) (members over 2 years of age)**	❑ **dronabinol capsule*** **	

All Non-Preferred Medications Require Prior Authorization			
❑ Akynzeo®	❑ Aloxi®	❑ Antivert®	❑ Anzemet®
❑ aprepitant capsule/pack	❑ Bonjesta®	❑ Cesamet®	❑ Cinvanti™
❑ Compazine® supp/tab	❑ Compro®	❑ dimenhydrinate	❑ dimenhydrinate
❑ Emend® Bi Pak	❑ Emend® susp	❑ Emend® Tri-fold pack	❑ granisetron
❑ granisetron	❑ Kytril®	❑ Marinol®	❑ metoclopramide ODT
❑ Metozolv® ODT	❑ palonosetron (generic Aloxi®)	❑ Phenergan®	❑ prochlorperazine supp
❑ promethazine 50mg supp, vial, ampule	❑ Reglan®	❑ Sancuso® patch	❑ scopolamine (generic Transderm-Scop®)
❑ Syndros™	❑ Tigan®	❑ Transderm-Scop®	❑ trimethobenzamide
❑ Varubi®	❑ Vistaril®	❑ Zofran® ODT/soln/tab	❑ Zuplenz® film

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MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

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

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight: _____ **Date:** _____

DIAGNOSIS AND CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

1. Diagnosis of severe, chemotherapy induced nausea and vomiting? ❑ Yes ❑ No
2. If diagnosis is AIDS-related wasting, has member 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 doses of, or has adverse effects or contraindications to **TWO (2)** different conventional antiemetics **(e.g., promethazine, prochlorperazine, meclizine, metoclopramide, dexamethasone, etc.)**? ❑ Yes ❑ No
5. Member has hyperemesis (pregnancy-related nausea/vomiting)? ❑ Yes ❑ No
6. **Bonjesta®/Diclegis®:** length of approval, Estimated Delivery Date (EDD)
   Member must be pregnant and at least 18 years of age ❑ Yes ❑ No

   Estimated Delivery Date: _____

   If requesting **Bonjesta®**, member must have tried and failed **Diclegis®** ❑ Yes ❑ No

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7. Does the member have diabetic gastroparesis? If yes, list why oral metoclopramide cannot be used.

❑ Yes ❑ No

_____

_____

8. Provide clinical evidence that the **Preferred** drug(s) will not provide adequate benefit and list pharmaceutical drugs attempted and outcome.

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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.