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.**

The Sentara Health Plans Oncology Program is administered by OncoHealth

- **For any oncology indications**, the most efficient way to submit a prior authorization request is through the**OncoHealth OneUM Provider Portal** at https://oneum.oncohealth.us. Fax to **1-800-264-6128.** OncoHealth can also be contacted at Phone: 1-888-916-2616

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 (4mg, 8mg)/tab/soln**	❑ **meclizine (OTC, Rx)**
❑ **metoclopramide (tab/soln/vial)**	❑ **Phenadoz® supp (AG) (members over 2 years of age)**	❑ **Prochlorperazine tab**
❑ **promethazine (AG) (members over 2 years of age)**	❑ **dronabinol capsule*** **	

All Non-Preferred Medications Require Prior Authorization			
❑ **Akynzeo®**	❑ **Aloxi®**	❑ **Antivert®**	❑ **Aponvie™**
❑ **Aprepitant capsule/pack**	❑ **Barhemsys®**	❑ **Bonjesta®**	❑ **Cesamet®**
❑ **Cinvanti™**	❑ **Compazine® supp/tab**	❑ **Compro®**	❑ **dimenhydrinate tab, vial**
❑ **Emend® Bi Pak**	❑ **Emend® susp**	❑ **Emend® Tri-fold pack**	❑ **Focinvez™**
❑ **Fosaprepitant vial**	❑ **granisetron** ❑ **Granisol soln**	❑ **Kytril®**	❑ **Marinol®**
❑ **metoclopramide ODT**	❑ **Nereus**	❑ **ondansetron 16mg ODT**	❑ **palonosetron (generic Aloxi®)**
❑ **prochlorperazine supp, vial**	❑ **promethazine 50mg supp, vial, ampule**	❑ **Reglan®**	❑ **Sancuso® patch**
❑ **scopolamine (generic Transderm-Scop®)**	❑ **Sustol®**	❑ **Syndros™**	❑ **trimethobenzamide**
❑ **Transderm-Scop®**	❑ **Varubi®**	❑ **Vistaril®**	❑ **Zofran®ODT/soln/tab**

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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:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

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

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

Weight (if applicable): _____ **Date weight obtained:** _____

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. Does the member have a 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. Does the member have 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, 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. For **ondansetron 16 mg ODT**:

   Has the member tried and failed or been intolerant to ondansetron 8 mg ODT? ❑ Yes ❑ No

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

   _____

   _____

   _____

   _____

10. For **Nereus (tradipitant):**

    Is this medication being used to treat or prevent motion sickness? ❑ Yes ❑ No

    Has the member tried and failed meclizine and promethazine? ❑ Yes ❑ No

*****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.****

REVISED/UPDATED/REFORMATTED: ~~6/30/2017; 7/17/2017; 8/31/2017; 3/22/2018; 7/1/2018; 8/16/2018; 10/23/2018; 3/31/2019; 6/12/2019; 12/7/2019; 6/18/2020; 1/5/2022; 1/6/2022; 6/27/2022; 9/20/2022; 12/21/2023; 1/18/2024; 2/8/2024; 11/22/2024; 12/17/2024;~~ 2/28/2025; **6/4/2026**