



2020 Oral ondansetron (generic Zofran®) Prior Authorization Request

Page 1 of 2

(You must complete both pages.)

Fax completed form to: 1-800-408-2386

For urgent requests, please call: 1-800-414-2386

Patient information		Prescriber information	
Patient name		Today's date	Physician specialty
Patient insurance ID number		Physician name	NPI/DEA number
Patient address, city, state, ZIP		Physician address, city, state, ZIP	
Patient home telephone number		MD office telephone number	
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Patient date of birth	MD office fax number	
Diagnosis and medical information			
Medication requested			Frequency
<input type="checkbox"/> ondansetron HCl oral: <input type="checkbox"/> 4 mg tablet <input type="checkbox"/> 8 mg tablet <input type="checkbox"/> 24 mg tablet <input type="checkbox"/> 4 mg/5ml oral solution			
<input type="checkbox"/> ondansetron orally disintegrating tablets (ODT): <input type="checkbox"/> 4 mg ODT tablet <input type="checkbox"/> 8 mg ODT tablet			
New prescription OR date therapy initiated		Quantity	Day supply
Expected length of therapy			
Diagnosis (<i>Please check all boxes that apply and include all office notes supporting diagnosis.</i>)			
<input type="checkbox"/> Chemotherapy-induced nausea and vomiting, highly emetogenic chemotherapy; prophylaxis			
<input type="checkbox"/> Chemotherapy-induced nausea and vomiting, moderately emetogenic chemotherapy; prophylaxis			
<input type="checkbox"/> Postoperative nausea and vomiting; prophylaxis			
<input type="checkbox"/> Radiation-induced nausea and vomiting; prophylaxis			
Other diagnosis/(ICD 10): _____			
Please check all boxes that apply:			
1. <input type="checkbox"/> Yes <input type="checkbox"/> No Is patient currently enrolled in hospice? If YES, please answer the following:			
<input type="checkbox"/> Yes <input type="checkbox"/> No Prescriber IS affiliated with the hospice facility AND medication requested is completely UNRELATED to the member's terminal illness or related hospice care.			
<input type="checkbox"/> Yes <input type="checkbox"/> No Prescriber IS affiliated with the hospice facility AND medication requested is RELATED to the member's terminal illness or related hospice care.			
<input type="checkbox"/> Yes <input type="checkbox"/> No Prescriber IS NOT affiliated with the hospice facility but attests that coordination with hospice facility has occurred AND medication requested is completely UNRELATED to the member's terminal illness or related hospice care.			
<input type="checkbox"/> Yes <input type="checkbox"/> No Prescriber IS NOT affiliated with the hospice facility but attests that coordination with hospice facility has occurred AND medication requested is RELATED to the member's terminal illness or related hospice care.			
<input type="checkbox"/> Yes <input type="checkbox"/> No Prescriber IS NOT affiliated with the hospice facility and has NOT coordinated care with the hospice facility			
Please provide the hospice facility name, phone number, fax number, and contact person below:			

(continued on page 2)

Please check all boxes that apply (continued):

2. Yes No **Is oral ondansetron being used for chemotherapy induced nausea and vomiting? If YES, complete the section below.**
- a. Cancer chemotherapy route of administration: Intravenous (IV) Oral (PO) Other: _____
- b. Where is the chemotherapy being administered? Home Hospital Outpatient infusion center Other: _____
- c. Yes No Will the patient be receiving **IV** antiemetics along with their **IV** chemotherapy regimen? (Examples of **IV** antiemetics include Aloxi, Decadron/dexamethasone, Benadryl/diphenhydramine, Compazine, Emend, etc.)
- d. Yes No Will the oral ondansetron be administered **more than 2 hours before** receiving **IV** chemotherapy?
- e. Yes No Can the patient use oral ondansetron **more than 48 hours after** receiving **IV** chemotherapy if needed for ongoing nausea/vomiting?

3. Yes No **The quantity limit for ondansetron oral solution 4mg/5ml is 900 ml per 30 days. Does the patient require a higher dosage (quantity limit exception)?**
- ▶ If **YES**, indicate quantity requested: _____ per 30 days OR quantity _____ per day
- The number of doses available under the dose restriction for the prescription drug has been ineffective in the treatment of the enrollee's disease or medical condition.
- The number of doses available under the dose restriction for the prescription drug, based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance.

4. **Please list all medications the patient has tried specific to the diagnosis and specify below.**

CURRENT/PAST MEDICATIONS USED	DATES OF TREATMENT	THERAPEUTIC OUTCOME

5. **Other supporting information**

*NOTE: All exception requests require prescriber supporting statements. Additionally, requests that are subject to prior authorization (or any other utilization management requirement), may require supporting information. Please attach supporting information, as necessary, for your request.

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that documentation supporting this information is available for review if requested by the health plan sponsor, or, if applicable, a state or federal regulatory agency. I understand that any person who knowingly makes or causes to be made a false record or statement that is material to a claim ultimately paid by the United States government or any state government may be subject to civil penalties and treble damages under both the federal and state False Claims Acts. See, e.g., 31 U.S.C. §§ 3729-3733. By signing this form, I represent that I have obtained patient consent as required under applicable state and federal law, including but not limited to the Health Information Portability and Accountability Act (HIPAA) and state re-disclosure laws related to HIV/AIDS.

Prescriber signature	Date
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