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2020 Oral ondansetron (generic Zofran®) Prior Authorization Request

(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 ☐ Male ☐ Female	Patient date of birth	MD office fax number	

Diagnosis and medical information

Medication requested

☐ ondansetron HCl: ☐ 4 mg tablet ☐ 8 mg tablet ☐ 24 mg tablet ☐ 4 mg/5ml oral solution

☐ ondansetron orally disintegrating tablets (ODT): ☐ 4 mg ODT tablet ☐ 8 mg ODT tablet

Frequency

New prescription OR date therapy initiated	**Quantity**	**Day supply**	**Expected length of therapy**

Diagnosis (*Please check all boxes that apply and include all office notes supporting diagnosis.)*

☐ Chemotherapy-induced nausea and vomiting, highly emetogenic chemotherapy; prophylaxis

☐ Chemotherapy-induced nausea and vomiting, moderately emetogenic chemotherapy; prophylaxis

☐ Postoperative nausea and vomiting; prophylaxis

☐ Radiation-induced nausea and vomiting; prophylaxis

Other diagnosis/(ICD 10): _____

Please check all boxes that apply:

1. ☐ Yes ☐ No **Is patient currently enrolled in hospice? If YES, please answer the following**:

☐ Yes ☐ No Prescriber **IS** affiliated with the hospice facility **AND** medication requested is completely **UNRELATED** to the member's terminal illness or related hospice care.

☐ Yes ☐ No Prescriber **IS** affiliated with the hospice facility **AND** medication requested is **RELATED** to the member's terminal illness or related hospice care.

☐ Yes ☐ 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.

☐ Yes ☐ 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.

☐ Yes ☐ 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)

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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 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**