

## ANTIEMETICS/ANTIVERTIGO AGENTS PRIOR AUTHORIZATION FORM

- Please submit **all** requested documentation with this request. Incomplete documentation may delay the processing of this request.
- To review the prior authorization guidelines for Antiemetics and Antivertigo Agents, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – **Antiemetics/Antivertigo Agents** (accessible at: <http://www.dhs.pa.gov/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm>).
- These agents are also subject to **quantity limits**. If the requested quantity exceeds the limit, please submit supporting chart documentation (refer to **Quantity Limits** list at: <http://www.dhs.pa.gov/provider/pharmacyservices/quantitylimitslist/index.htm>).

PRIOR AUTHORIZATION INFORMATION		PRESCRIBER INFORMATION	
<input type="checkbox"/> New request	<input type="checkbox"/> Additional info (PA# _____)	# of pages in request: _____	Prescriber name:
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
RECIPIENT INFORMATION		Street address:	
Recipient Name:		Suite #:	City/state/zip:
Recipient ID#:	DOB:	Phone:	Fax:

### CLINICAL INFORMATION

<b>Non-preferred medication requested:</b>			
<input type="checkbox"/> Akynzeo capsule	<input type="checkbox"/> dimenhydrinate injection	<input type="checkbox"/> phosphoric acid/dextrose/fructose OTC solution ( <i>generic Emetrol</i> )	<input type="checkbox"/> Tigan injection
<input type="checkbox"/> Anzemet tablet	<input type="checkbox"/> Dramamine OTC	<input type="checkbox"/> prochlorperazine injection	<input type="checkbox"/> Varubi tablet
<input type="checkbox"/> Anzemet injection	<input type="checkbox"/> granisetron tablet	<input type="checkbox"/> promethazine 50 mg suppository*	<input type="checkbox"/> Zofran ODT
<input type="checkbox"/> Cesamet tablet*	<input type="checkbox"/> Marinol capsule	<input type="checkbox"/> Reglan tablet	<input type="checkbox"/> Zofran solution
<input type="checkbox"/> Compazine rectal suppository	<input type="checkbox"/> Metozolv ODT	<input type="checkbox"/> Sancuso patch	<input type="checkbox"/> Zofran tablet
<input type="checkbox"/> Compro rectal suppository	<input type="checkbox"/> Phenergan injection ampule/vial	<input type="checkbox"/> Tigan capsule	<input type="checkbox"/> Zuplenz film
<input type="checkbox"/> Diclegis DR tablet	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____
<b>*For a promethazine agent for a Recipient ≤ 6 years old, please call Pharmacy Services. For Cesamet, use Cesamet form.</b>			
Strength:	Dose/directions:	Quantity:	Refills:
Diagnosis ( <i>submit documentation</i> ):		Dx code ( <i>required</i> ):	
1. Does the Recipient have a history of trial and failure, contraindication, or intolerance of the preferred Antiemetic/Antivertigo Agents? <i>Check all that apply.</i>		<input type="checkbox"/> Yes – <u>submit all supporting documentation of preferred agents tried and treatment outcomes, including contraindications or intolerances</u>  <input type="checkbox"/> No	
<input type="checkbox"/> Aloxi injection	<input type="checkbox"/> ondansetron tablet/ODT/solution		
<input type="checkbox"/> dimenhydrinate OTC tablet	<input type="checkbox"/> ondansetron injection vial/syringe		
<input type="checkbox"/> dronabinol capsule	<input type="checkbox"/> prochlorperazine tablet/suppository		
<input type="checkbox"/> Emend capsule/pack	<input type="checkbox"/> promethazine tablet/syrup*		
<input type="checkbox"/> Emend injection	<input type="checkbox"/> promethazine injection*		
<input type="checkbox"/> granisetron injection	<input type="checkbox"/> promethazine 12.5 mg/25 mg suppository*		
<input type="checkbox"/> meclizine Rx/OTC tablet	<input type="checkbox"/> Transderm Scop patch		
<input type="checkbox"/> metoclopramide tablet/solution	<input type="checkbox"/> trimethobenzamide capsule/injection		
<input type="checkbox"/> metoclopramide injection vial/syringe			

**PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION**

Prescriber Signature:	Date:
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