pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

ANTIEMETICS/ANTIVERTIGO AGENTS PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Antiemetics/Antivertigo Agents** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at http://www.dhs.pa.gov/provider/pharmacyservices/index.htm.

PRIOR AUTHORIZATION INFORMATION		PRESCRIBER INFORMATION	
☐New request ☐Renewal request	Total # of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
BENEFICIARY INFORMATION		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Non-preferred medication requested:

☐Akynzeo capsule	☐Diclegis DR tablet	☐Phenergan injection ampule	☐Tigan injection vial
☐Akynzeo injection vial	☐dimenhydrinate injection vial	☐Phenergan injection vial	☐Varubi tablet
☐Anzemet tablet	☐Emend injection vial	☐prochlorperazine injection vial	☐Zofran ODT
☐aprepitant capsule	☐Emend powder for suspension	☐Reglan tablet	☐Zofran solution
☐aprepitant dose pack	☐Marinol capsule	☐Sancuso patch	☐Zofran tablet
☐Bonjesta tablet	☐metoclopramide ODT	☐Sustol ER injection syringe	☐Zuplenz film
☐Cesamet capsule**	☐palonosetron injection syringe	☐Syndros solution	☐_____
☐Compro rectal suppository	☐palonosetron injection vial	☐Tigan capsule	

****For a promethazine agent for a beneficiary < 6 years old, please call Pharmacy Services. For Cesamet, use Cesamet form.**

Strength:	Dose/directions:	Quantity:	Refills:
Diagnosis (*submit documentation*):		Dx code (*required*):	

1. Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the preferred Antiemetic/Antivertigo Agents? *Check all that apply.*

☐Aloxi injection	☐ondansetron injection syringe or vial
☐Cinvanti injection	☐ondansetron ODT, solution, or tablet
☐dimenhydrinate OTC tablet	☐prochlorperazine rectal suppository
☐dronabinol capsule	☐prochlorperazine tablet
☐Emend capsule or TriPack	☐promethazine injection ampule or vial**
☐granisetron injection	☐promethazine rectal suppository**
☐granisetron tablet	☐promethazine syrup or tablet**
☐meclizine OTC or Rx tablet	☐Transderm Scop patch
☐metoclopramide injection syringe or vial	☐trimethobenzamide capsule
☐metoclopramide solution or tablet	

☐Yes – *Submit documentation of medication regimens tried and treatment response, contraindications, and/or intolerances.*

☐No

2. ***If the requested agent is being administered as part of a fixed schedule related to chemotherapy,*** please specify how often the beneficiary is receiving chemotherapy.

☐every _____ weeks
☐other: _____

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

Prescriber Signature:	**Date**: