

# UPMC HEALTH PLAN

## Anti-Emetic Medications

**Emend, Anzemet, Aloxi, Sancuso, Kytril, Granisol**

### Prior Authorization Form

IF THIS IS AN URGENT REQUEST, Please Call UPMC Health Plan Pharmacy Services.

Otherwise please return completed form to:

UPMC HEALTH PLAN PHARMACY SERVICES

PHONE 800-396-4139

FAX 412-454-7722

**PLEASE TYPE OR PRINT NEATLY**

*Please complete all sections of this form AND include details of past relevant medical treatment, which substantiates the need for an exception to using formulary alternatives, i.e. past prescription treatment failures, documented side effects, chart documentation, lab values, etc. Incomplete responses may delay this request.*

<b>Office Contact:</b>		<b>Provider Specialty:</b>	
<b>Provider First Name:</b>		<b>Provider Last Name:</b>	
<b>Provider Phone:</b>		<b>Provider Fax:</b>	<b>Provider NTI #:</b>
<b>Patient Name:</b>	<b>Patient UPMC Health Plan ID Number:</b>	<b>Patient DOB:</b>	<b>Patient Age:</b>
<b>Drug Requested:</b> <input type="checkbox"/> Brand <input type="checkbox"/> Generic	<b>Strength:</b>	<b>Frequency:</b>	<b>Qty Dispensed:</b>
<i>Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.</i>			
<input type="checkbox"/> New medication	<input type="checkbox"/> Ongoing medication	<b>If ongoing, provide date started:</b>	
<b>Diagnosis:</b>		<b>Date of diagnosis:</b>	
<b>Please indicate place of administration / infusion?</b>	<input type="checkbox"/> Physician's Office <input type="checkbox"/> Hospital/Facility	<b>Please indicate how medication will be billed:</b>	
<b>Please provide facility/provider name and address:</b>		<input type="checkbox"/> Billed directly by the provider via JCODE Provide JCODE: _____	
		<input type="checkbox"/> Billed by a pharmacy and delivered to the provider	
		<input type="checkbox"/> Billed by a pharmacy and delivered to the patient	

### Medical History

<b>Has the member tried and failed oral ondansetron (Zofran)?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
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### HISTORY OF PREVIOUS MEDICATIONS USED TO TREAT THE ABOVE CONDITION

Medication Trial/ Previous Therapies	Date of Therapy Start Date    End Date	Strength	Frequency	List adverse reactions/side effects/ reason for discontinuing

**Please provide any additional information which should be considered in the space below:**
