

ALOXI (palonosetron)

PRIOR AUTHORIZATION REQUEST FORM

Patient Information	
Name:	Member ID #:
Group Name:	Date of Birth:
Diagnosis:	Diagnosis Code:

Provider Information	
Prescriber's Name:	Prescriber's DEA #:
Phone:	Fax:
Office Address:	

Complete and review information, sign and date. Fax signed form to Caremark's prior authorization department at 1-888-836-0730. The Caremark fax machine is located in a secure location as required by HIPAA regulations. On behalf of the member's health plan, Caremark assists in the administration of the prior authorization program. Caremark is an independent company that administers prescription drug benefits.

Providers may call Caremark at 1-800-294-5979 with any questions concerning prior authorization procedures. Members should call Caremark Customer Care at 1-888-963-7290 with any questions. Members may also call their health plan at the number indicated on their Member ID cards.

Please circle the appropriate answer for each applicable question (Y for Yes, N for No).

1. Does the patient require more than the following limits per 15 days? Y N
- Aloxi 0.25mg/5mL or 0.075mg/1.5 mL injection - 5 mL
 - Anzemet 50mg and 100mg tablets - 3 tablets
 - Anzemet 100mg/5 mL or 12.5mg/0.625mL injection - 15 mL
 - Kytril 1mg tablets - 6 tablets
 - Granisetron 1mg/5 mL oral solution - 30 mL
 - Kytril 0.1mg/mL or 1mg/mL injection - 1mL
 - Sancuso 3.1mg/24 hours patches - 2 patches
 - Zofran 4mg tablets/ODT - 9 tablets
 - Zofran 8mg tablets/ODT - 6 tablets
 - Zofran 24mg tablet - 1 tablet
 - Zofran 4mg/5mL oral solution - 50 mL
 - Ondansetron 32mg/50mL injection - 50mL
 - Zofran 2 mg/mL injection - 10mL
 - Zuplenz 4mg oral soluble films - 9 oral soluble films
 - Zuplenz 8mg oral soluble films - 6 oral soluble films

[If the answer to this question is no, a prior authorization is not required. (These quantities are available without a prior authorization.)]

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|---|---|---|
| 2. Is the patient receiving moderate to highly emetogenic chemotherapy?
[If the answer to this question is yes, may skip to question 5.] | Y | N |
| 3. Is the patient receiving total body irradiation?
[If the answer to this question is yes, may skip to question 5.] | Y | N |
| 4. Is the patient receiving fractionated abdominal irradiation?
[If the answer to this question is yes, may skip to question 6.] | Y | N |
| 5. How many days per month does the patient receive nausea/emesis-inducing therapy?
[No further questions required.] | Y | N |
| 6. Is this request for Kytril, Sancuso or Zofran?
[If the answer to this question is no, then no further questions are required.] | Y | N |
| 7. Does the patient require Kytril, Sancuso or Zofran for hyperemesis gravidarum? | Y | N |

Comments:

I affirm that the information given on this form is accurate as of this date.

Prescriber (or Authorized) Signature and Date:
