



If the following information is not complete, correct, or legible, the PA process can be delayed.

Please use one form per member.

MEMBER INFORMATION

Last Name:

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First Name:

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Medicaid ID Number:

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Date of Birth:

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Gender: Male Female

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Last Name:

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First Name:

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NPI Number:

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Phone Number:

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Fax Number:

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DRUG INFORMATION

Does NOT require PA: ondansetron (ODT/tab) (Max Qty Per fill = 60); meclizine; metoclopramide (tab/sol) Prochlorperazine (tab/syrup); promethazine in members over 2 years of age.

Requires submission of this PA: preferred Dronabinol plus all non-preferred medications:

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Akynzeo® | <input type="checkbox"/> Aloxi® | <input type="checkbox"/> Antivert® | <input type="checkbox"/> Anzemet® |
| <input type="checkbox"/> aprepitant cap/pack | <input type="checkbox"/> Bonjesta™ | <input type="checkbox"/> Cesamet® | <input type="checkbox"/> Cinvanti™ |
| <input type="checkbox"/> Compazine® supp/tab | <input type="checkbox"/> Compro® | <input type="checkbox"/> Diclegis® | <input type="checkbox"/> dimenhydrinate |
| <input type="checkbox"/> doxylamine succ/vit B6 | <input type="checkbox"/> Emend® Bi Pak | <input type="checkbox"/> Emend® cap | <input type="checkbox"/> Emend® susp |
| <input type="checkbox"/> Emend® Tri-fold pack | <input type="checkbox"/> granisetron | <input type="checkbox"/> hydroxyzine | <input type="checkbox"/> Kytril® |
| <input type="checkbox"/> Marinol® | <input type="checkbox"/> metoclopramide ODT | <input type="checkbox"/> Metozolv® ODT | <input type="checkbox"/> ondansetron soln |
| <input type="checkbox"/> palonosetron | <input type="checkbox"/> Phenergan® | <input type="checkbox"/> prochlorperazine sup | <input type="checkbox"/> promethazine 50mg supp |
| <input type="checkbox"/> Reglan® | <input type="checkbox"/> Sancuso® patch | <input type="checkbox"/> scopolamine | <input type="checkbox"/> Syndros® |
| <input type="checkbox"/> Tigan® | <input type="checkbox"/> Transderm-Scop® | <input type="checkbox"/> trimethobenzamide | <input type="checkbox"/> Varubi® |
| <input type="checkbox"/> Vistaril® | <input type="checkbox"/> Zofran® ODT/soln/tab | <input type="checkbox"/> Zuplenz® film | |

(Form continued on next page.)

<https://mediproviders.anthem.com/va>

Antiemetic/Antivertigo Medications

Member's Last Name:

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Member's First Name:

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Drug Name/Form: _____

Strength: _____

Dosing Frequency: _____

Length of Therapy: _____

Quantity per Day: _____

DIAGNOSIS AND MEDICAL INFORMATION

1. Diagnosis of severe, chemotherapy-induced nausea and vomiting?
 Yes No
2. If diagnosis is AIDS-related wasting, has member tried and failed megestrol acetate oral suspension **OR** has a contraindication, intolerance, drug-drug interaction?
 Yes No
3. Nausea or vomiting related to radiation therapy, moderate to highly emetogenic chemotherapy, or post-operative nausea and vomiting?
 Yes No
4. Member has tried and failed therapeutic doses of, or has adverse effects or contraindications to, **TWO** different conventional antiemetics (e.g., promethazine, prochlorperazine, meclizine, metoclopramide, dexamethasone, etc.)
 Yes No
5. Member has hyperemesis (pregnancy-related nausea/vomiting)?
 Yes No
6. Provide clinical evidence that the preferred agent(s) will not provide adequate benefit and list pharmaceutical agents attempted and outcome.

Prescriber Signature (Required)

Date

By signature, the Physician confirms the above information is accurate and verifiable by member records.

Please include ALL requested information; Incomplete forms will delay the PA process.

Submission of documentation does NOT guarantee coverage.

The completed form may be **FAXED TO 1-844-512-7020**.