AmeriHealth Caritas

Iowa

AmeriHealth Caritas Iowa
Request for Prior Authorization

Antiemetic-5HT3 Receptor Antagonists/ Substance P Neurokinin Products

Form applies to IA Health Link and ***hawk-i*** plans.

Please print – accuracy is important.

Fax completed form to 1-855-825-2714. Provider Help Desk: 1-855-328-1612.

AmeriHealth Caritas Iowa member ID #:		Patient name:	
Patient address:			DOB:
Provider NPI:	Prescriber name:		Phone:
Prescriber address:			Fax:
Pharmacy name:			
Address:			Phone:
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.			
Pharmacy NPI:		Pharmacy fax:	NDC:

Prior authorization is required for preferred Antiemetic-5HT3 Receptor Antagonists/Substance P Neurokinin medications for quantities exceeding the dosage limits provided in parentheses. Payment for Antiemetic-5HT3 Receptor Agonists/Substance P Neurokinin Agents beyond this limit will be considered on an individual basis after review of submitted documentation.

Prior authorization will be required for all non-preferred Antiemetic-5HT3 Receptor Antagonists/Substance P Neurokinin medications beginning the first day of therapy. Payment for non-preferred medications will be authorized only for cases in which there is documentation of previous trial(s) and therapy failure with a preferred agent in this class. Note: Aprepitant (Emend®) will only be payable when used in combination with other antiemetic agents (5-HT3 medication and dexamethasone) for patients receiving highly emetogenic cancer chemotherapy.

Please note: AmeriHealth Caritas Iowa uses Iowa Medicaid Enterprise criteria. For complete criteria, please consult www.iowamedicaidpdl.com/pa_criteria.

Preferred

☐ Emend 80mg capsules (8)
☐ Emend 125mg capsules (4)
☐ Ondansetron 2mg/mL (4 – 20mL vials)
☐ Ondansetron 2mg/mL (8 – 2mL vials)
☐ Ondansetron 4mg tablets (60)
☐ Ondansetron 8mg tablets (60)
☐ Ondansetron ODT 4mg tablets (60)
☐ Ondansetron ODT 8mg tablets (60)

Non-Preferred

☐ Akynzeo (2)
☐ Aloxi 0.25mg/5mL (4 vials)
☐ Anzemet 50mg & 100mg tablets (5)
☐ Anzemet 100mg/5mL (4 vials)
☐ Anzemet 12.5mg/0.625mL (8 ampules)
☐ Apreptitant
☐ Granisetron 1mg tablets (8)
☐ Granisetron 1mg/mL (8 vials)
☐ Granisetron 4mg/4mL (2 vials)
☐ Granisetron 4mg/5mL oral solution (50mL/month)
☐ Sancuso Patch
☐ Zuplenz
☐ Varubi

Strength: Dosage Instructions: Quantity: Days Supply:

Diagnosis:

Medical reasoning for therapy exceeding dosage limits:

Reason for use of non-preferred drug requiring prior approval:

Please print – accuracy is important.

Attach lab results and other documentation as necessary.

By signing this document, I attest that the information contained herein is true and accurate to the best of my knowledge and belief. By submitting this form, I acknowledge that I am submitting a request for authorization of health care services, and I agree to abide by and adhere to established federal and Iowa fraud, waste and abuse (FWA) rules and regulations and to remain in compliance with AmeriHealth Caritas Iowa's Program Integrity rules. I further attest that any claim I submit is subject to investigations, review or audit as determined by AmeriHealth Caritas Iowa. I further acknowledge that an authorization is not a guarantee of payment.	
Prescriber signature: (Must match prescriber listed above.)	Date of submission:

Important note: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.

Check www.amerihealthcaritasia.com/Provider to confirm your version of this form.