Aloxi, Cinvanti, Emend, Sustol, Varubi

Prior Authorization Request

CVS Caremark administers the medical drug prior authorization program on behalf of Harvard Pilgrim Health Care. Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form to CVS Caremark, toll-free at 1-844-851-0882** to initiate the review process. If you have questions regarding the prior authorization please contact CVS Caremark at **1-844-387-1435.**

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____ **NPI#:** _____
Specialty: _____ **HPHC Provider ID**_____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Rendering Provider Info: ❑ **Same as Requesting Provider** **HPHC Provider ID:**_____
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____ **Provider Tax ID:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Additional Demographic Information:

Please indicate the place of service for the requested drug:
❑ *Ambulatory Surgical* ❑ *Home* ❑ *Inpatient Hospital* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office* ❑ *Pharmacy*

Drug Information:
*Strength/Measure*_____ *Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un
*Directions(sig)*_____ *Route of administration*_____
*Dosing frequency*_____

Criteria Questions:

1. What is the diagnosis?
   ❑ Nausea and vomiting related to oncology, post-radiation therapy, post-surgery, or eating disorders
   ❑ Nausea and vomiting related to oncology only
   ❑ Other_____
2. What is the ICD-10 code? _____
3. Does the patient have documented use of a moderate or high emetogenic potential IV antineoplastic agent listed in the most recent NCCN Guidelines? ❑ Yes ❑ No
4. What is the requested drug?
   ❑ Aloxi injection
   ❑ Cinvanti injection, *Skip to #6*
   ❑ Emend injection
   ❑ Sustol injection, *Skip to #8*
   ❑ Varubi injection, *Skip to #6*
5. Has the patient tried and failed oral and/or IV Zofran, Kytril, or Anzemet? ❑ Yes ❑ No *Any answer, Skip to #9*

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-844-851-0882

 Aloxi/Cinvanti/Emend/Sustol/Varubi HPHC – 12/2018.

6. Will the requested drug be used as a part of combination therapy with dexamethasone and a 5-HT3 antagonist [e.g., palonosetron (Aloxi), granisetron (Kytril), ondansetron (Zofran), dolasetron (Anzemet)]?
   If Yes, Skip to #9 ❑ Yes ❑ No

7. Does the patient have an intolerance or contraindication to dexamethasone and/or a 5-HT3 antagonist [e.g., palonosetron (Aloxi), granisetron (Kytril), ondansetron (Zofran), dolasetron (Anzemet)?
   ❑ Yes ❑ No *Any answer, Skip to #9*

8. Will the requested drug be used as part of combination therapy with dexamethasone? ❑ Yes ❑ No

9. Is the patient currently receiving Aloxi Injection, Cinvanti Injection, Emend Injection, Sustol Injection, or Varubi Injection? ❑ Yes ❑ No *If No, no further questions*

10. Has the prescriber provided in the patient's chart documentation outlining continued need for therapy?
    ❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-844-851-0882

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Phone: 1-844-387-1435 ● Fax: 1-844-851-0882 ● www.caremark.com