HEALTH PLANS
UNIVERSITY OF UTAH

MEDICAL PHARMACY PRIOR AUTHORIZATION REQUEST FORM

ANTIEMETICS

Akynzeo IV® (fosaprepitant/palonosetron); Cinvanti® IV (aprepitant); Emend IV® (fosaprepitant)

For authorization, please answer each question and fax this form PLUS chart notes back to the U of U Health Plans Prior Authorization Department at 801-213-1547. Failure to submit clinical documentation to support this request will result in delay and/or denial of the request.

If you have medical pharmacy prior authorization questions, please call for assistance: Healthy U: 833-981-0212, Individual Exchange: 833-981-0214, Commercial Groups: 833-981-0213, MHC: 844-262-1560, Advantage U Part B: 888-605-0858

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		HCPCS Code:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Preferred:
NK1 antagonist: , ☐ Cinvanti® (aprepitant), ☐ Emend IV® (fosaprepitant)
5-HT3 antagonists: ☐ granisetron, ☐ ondansetron, ☐ palonosetron

Non-preferred:
5-HT3/NK1 combination: ☐ Akynzeo IV® (fosaprepitant/palonosetron)

Dosing/Frequency:____

Questions	Yes	No	Comments/Notes
AKYNZEO® IV			
1. Is this request for prevention of nausea and vomiting associated with moderately to highly emetogenic intravenous chemotherapy regimens? 2. Has the member tried and failed aprepitant and fosaprepitant in combination with palonosetron?	☐	☐	**Please provide documentation**
CINVANTI®IV, EMEND® IV			
1. Is this request for prevention of nausea and vomiting associated with moderately to highly emetogenic intravenous chemotherapy regimens? 2. Will the member be taking a 5-HT3 antagonist and a corticosteroid in combination with the requested product?	☐	☐	

Confidentiality Notice
This document and any accompanying document contain confidential information and is intended for the use of the individual or entity named on this transmission sheet. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or the taking of any action in reliance on the contents of this information is strictly prohibited and the document should be returned to this office immediately. If you have received this facsimile in error, please notify us by telephone immediately and destroy document received.

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.
Additional information:
Physician Signature:

****Failure to submit clinical documentation to support this request will result in delay and/or denial of the request****

Policy: PHARM- M028
Origination Date: 08/27/2020
Reviewed/Revised Date: 08/28/2020
Next Review Date: 08/28/2021
Current Effective Date: 09/01/2020

Confidentiality Notice

This document and any accompanying document contain confidential information and is intended for the use of the individual or entity named on this transmission sheet. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or the taking of any action in reliance on the contents of this information is strictly prohibited and the document should be returned to this office immediately. If you have received this facsimile in error, please notify us by telephone immediately and destroy document received.