PRIORITY PARTNERS
7231 Parkway Dr., Suite 100
Hanover, MD 21076

JOHNS HOPKINS
HEALTH PLANS

Prior Authorization

JOHNS HOPKINS HEALTH PLANS (MEDICAID)

Antiemetics - Priority Partners MCO

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Johns Hopkins Health Plans at **1-410-424-4607**. Please contact Johns Hopkins Health Plans at **1-888-819-1043** with questions regarding the Prior Authorization process.
When conditions are met, we will authorize the coverage of Antiemetics - Priority Partners MCO.

Drug Name
(specify drug) ______________________________

Quantity | Frequency | Strength

Route of Administration | Expected Length of Therapy

Patient Information
Patient Name: ______________________
Patient ID: ______________________
Patient Group No.: ______________________
Patient DOB: ______________________
Patient Phone:

Prescribing Physician
Physician Name: ______________________
Physician Phone: ______________________
Physician Fax: ______________________
Physician Address: ______________________
City, State, Zip: ______________________

Diagnosis: ______________________ **ICD Code:** ______________________

Comments: ______________________

Please circle the appropriate answer for each question.

1.	Is this request for continuation of therapy?	Y N
	[Note: The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.]	
	[If no, then skip to question 3.]	
2.	Is the patient experiencing a beneficial response to treatment?	Y N
	[Note: Documentation must be submitted.]	

	[No further questions.]		
3.	Is this request for Varubi?	Y N	
	[If no, then skip to question 5.]		
4.	Has the patient tried and failed formulary generic aprepitant (Emend) for a clinically appropriate indication?	Y N	
	[Note: Documentation must be submitted.]		
	[If yes, then skip to question 11.]		
	[If no, then no further questions.]		
5.	Is this request for a non-formulary antiemetic?	Y N	
	[If no, then skip to question 7.]		
6.	Has the patient tried and failed at least 2 formulary antiemetics for a clinically appropriate indication?	Y N	
	[Note: Documentation must be submitted.]		
	[If yes, then skip to question 11.]		
	[If no, then no further questions.]		
7.	Is this request for the use of ondansetron in pregnancy?	Y N	
	[If no, then skip to question 11.]		
8.	Has the patient been diagnosed with hyperemesis gravidarum?	Y N	
	[If no, then no further questions.]		
9.	Does the patient meet all of the following criteria: A) Persistent vomiting despite nonpharmacologic therapy and therapy with at least 2 pregnancy category B antiemetics (dimenhydrinate, diphenhydramine, meclizine, and metoclopramide), B) Maternal fluid status is compromised, C) Maternal weight is decreased or remains unchanged from pre-pregnancy?	Y N	
	[Note: Documentation must be submitted.]		
	[If yes, then no further questions.]		
10.	Is the patient being transitioned from IV antiemetics received during a hospital inpatient stay?	Y N	
	[Note: Documentation must be submitted.]		
	[No further questions.]		
11.	Is this request for an antiemetic that exceeds the quantity limit or Food and Drug Administration (FDA)-approved dosing?	Y N	
	[If no, then no further questions.]		
12.	Is this request for a 5-HT3 receptor antagonist (dolasetron, granisetron, ondansetron, palonosetron)?	Y N	
	[If no, then skip to question 14.]		
13.	Is the patient using the antiemetic for postoperative nausea and vomiting, and is undergoing more than one operative procedure in the month?	Y N	

[Note: Documentation must be submitted.]		
[If yes, then no further questions.]		
14. Is the patient undergoing more than one course of chemotherapy and/or radiation per month?	Y N	
[Note: Documentation must be submitted.]		

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date