TRICARE Prior Authorization Request Form for
ondansetron 16 mg ODT

JOHNS HOPKINS
HEALTH PLANS
7231 Parkway Drive, Suite 100, Hanover, MD 21076

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Prior Authorization does not expire.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: ____________________ Physician Name: ____________________
Address: ____________________ Address: ____________________
____________________ ____________________
Sponsor ID # ____________________ Phone #: ____________________
Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. Does the provider acknowledge that this drug has been identified as having cost-effective alternatives, and ondansetron 4 mg and 8 mg tablets and ODTs are available without prior authorization?	☐ **Yes** **Proceed to question 2**	☐ **No** **STOP** **Coverage not approved**
2. Please explain why the patient cannot use preferred formulations of ondansetron.	____________________ **Sign and date below**	

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

____________________ ____________________
Prescriber Signature Date

[02 April 2025]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: