



Prior Authorization
JOHNS HOPKINS HEALTHCARE (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 Healthcare at 1-410-424-4607 . Please contact Johns Hopkins Healthcare 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: _____
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Comments: _____

Please circle the appropriate answer for each question.	
1. Is this request for continuation of therapy?	<input type="checkbox"/> Y <input type="checkbox"/> 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?	<input type="checkbox"/> Y <input type="checkbox"/> N
[Note: Documentation must be submitted.]	

[No further questions.]	
3. Is this request for Varubi?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, then skip to question 5.]	
4. Has the patient tried and failed formulary generic aprepitant (Emend) for a clinically appropriate indication?	<input type="checkbox"/> Y <input type="checkbox"/> 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?	<input type="checkbox"/> Y <input type="checkbox"/> 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?	<input type="checkbox"/> Y <input type="checkbox"/> 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?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, then skip to question 11.]	
8. Has the patient been diagnosed with hyperemesis gravidarum?	<input type="checkbox"/> Y <input type="checkbox"/> 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?	<input type="checkbox"/> Y <input type="checkbox"/> 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?	<input type="checkbox"/> Y <input type="checkbox"/> 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?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, then no further questions.]	
12. Is this request for a 5-HT3 receptor antagonist (dolasetron, granisetron, ondansetron, palonosetron)?	<input type="checkbox"/> Y <input type="checkbox"/> 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?	<input type="checkbox"/> Y <input type="checkbox"/> 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?	<input type="checkbox"/> Y <input type="checkbox"/> 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
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