



Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
 P.O. Box 2586, Worcester, MA 01613-2586
Fax: (877) 208-7428 **Phone:** (800) 745-7318

Antiemetics Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the requesting provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

Additional information about these agents, including PA requirements and preferred products, can be found within the MassHealth Drug List at www.mass.gov/druglist.

Member information

Last name _____ First name _____ MI _____
 MassHealth member ID # _____ Date of birth _____
 Gender (Check one.) F M Member's place of residence home nursing facility

Medication information

Medication requested

- | | |
|---|--|
| <input type="checkbox"/> Akynzeo (fosnetupitant/palonosetron injection) > 2 vials/28 days | <input type="checkbox"/> granisetron tablet > 2 tablets/28 days |
| <input type="checkbox"/> Akynzeo (netupitant/palonosetron capsule) > 2 capsules/28 days | <input type="checkbox"/> ondansetron 24 mg tablet |
| <input type="checkbox"/> aprepitant 40 mg, 125 mg capsule > 2 capsules/28 days | <input type="checkbox"/> ondansetron solution |
| <input type="checkbox"/> aprepitant 80 mg > 4 capsules/28 days | <input type="checkbox"/> palonosetron 0.25 mg/2 mL injection > 2 units/28 days |
| <input type="checkbox"/> aprepitant trifold pack > 2 packs/28 days | <input type="checkbox"/> palonosetron 0.25 mg/5 mL injection > 2 units/28 days |
| <input type="checkbox"/> Bonjesta (doxylamine/pyridoxine extended-release) | <input type="checkbox"/> Sancuso (granisetron transdermal system) |
| <input type="checkbox"/> Cinvanti (aprepitant injectable emulsion) | <input type="checkbox"/> Sustol (granisetron extended-release injection) > 2 units/28 days |
| <input type="checkbox"/> doxylamine/pyridoxine delayed-release | <input type="checkbox"/> Varubi (rolapitant) > 2 tablets or vials/28 days |
| <input type="checkbox"/> Emend (aprepitant 125 mg powder for oral suspension) > 6 units/28 days | <input type="checkbox"/> Zuplenz (ondansetron film) |
| <input type="checkbox"/> fosaprepitant injection > 2 vials/28 days | |

Dose, frequency and duration of requested medication _____

Indication (Check all that apply.)

- | | |
|--|---|
| <input type="checkbox"/> Chemotherapy-induced nausea and vomiting (CINV) | <input type="checkbox"/> Postoperative nausea and vomiting (PONV) |
| <input type="checkbox"/> Hyperemesis gravidarum | <input type="checkbox"/> Radiation-induced nausea and vomiting (RINV) |
| | <input type="checkbox"/> Other _____ |

Section I. Please complete for Cinvanti requests.

Has the member had a trial of aprepitant or fosaprepitant injection?

Yes. Please list the dates/duration of trial and outcomes below.

Dates/duration of use _____

Did the member experience any of the following? Adverse reaction Inadequate response Other

Briefly describe details of adverse reaction, inadequate response, contraindication, or other.

 No. (Please explain why.) _____

Section II. Please complete for Akynzeo, aprepitant, fosaprepitant injection, granisetron tablet, palonosetron, Sustol, and Varubi requests exceeding the quantity limit.

Please describe the medical necessity for exceeding the quantity limit.

Section III. Please complete for ondansetron solution and Zuplenz requests.

1. Does the member have a medical condition in which they are unable to swallow tablets/capsules?

Yes. (Please list reason.) _____

No. (Please provide clinical rationale why conventional dosage forms cannot be used.) _____

2. For Zuplenz requests, please attach medical records documenting an inadequate response or adverse reaction to ondansetron ODT. Please include clinical rationale for use of the requested formulation over ondansetron ODT.

Section IV. Please complete for ondansetron 24 mg tablet requests.

Please provide clinical rationale for the use of the requested strength.

Section V. Please complete for Sancuso requests.

Has the member had a trial of ondansetron ODT?

Yes. Please list the dates/duration of trial and outcomes below.

Dates/duration of use _____

Did the member experience any of the following? Adverse reaction Inadequate response Other

Briefly describe details of adverse reaction, inadequate response, contraindication, or other.

 No. (Please explain why.) _____

Section VI. Please complete for Bonjesta and doxylamine/pyridoxine delayed-release requests.

1. Has the member had a trial of pyridoxine?

Yes. Please list the dates/duration of trial and outcomes below.

Dates/duration of use _____

Did the member experience any of the following? Adverse reaction Inadequate response Other

Briefly describe details of adverse reaction, inadequate response, contraindication, or other.

 No. (Please explain why.) _____

2. Has the member had a trial of doxylamine?

Yes. Please list the dates/duration of trial and outcomes below.

Dates/duration of use _____

Did the member experience any of the following? Adverse reaction Inadequate response Other

Briefly describe details of adverse reaction, inadequate response, contraindication, or other.

No. (Please explain why.) _____

Section VII. Please complete for all requests for non-preferred drug products if one or more preferred drug products have been designated for this class of drugs.

If one or more preferred drug products have been designated for this class of drugs, and if you are requesting PA for a non-preferred drug product, please provide medical necessity for prescribing the non-preferred drug product rather than the preferred drug product.

Prescriber information

Last name* _____ First name* _____ MI _____

NPI* _____ Individual MH Provider ID _____

DEA No. _____ Office Contact Name _____

Address _____ City _____ State _____ Zip _____

E-mail address _____

Telephone No.* _____ Fax No.* _____

* *Required*

Prescribing provider's attestation, signature, and date

I certify under the pains and penalties of perjury that I am the prescribing provider identified in the Prescriber information section of this form. Any attached statement on my letterhead has been reviewed and signed by me. I certify that the medical necessity information (per 130 CMR 450.204) on this form is true, accurate, and complete, to the best of my knowledge. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

Prescribing provider's signature (Signature and date stamps, or the signature of anyone other than the provider, are not acceptable.)

Signature required _____

Printed name of prescribing provider _____ Date _____