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

Print Clear

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

- ☐ Akynzeo (fosnetupitant/palonosetron injection) > 2 vials/28 days
- ☐ Akynzeo (netupitant/palonosetron capsule) > 2 capsules/28 days
- ☐ Anzemet (dolasetron tablet)
- ☐ aprepitant 40 mg, 125 mg capsule > 2 capsules/28 days
- ☐ aprepitant 80 mg > 4 capsules/28 days
- ☐ aprepitant trifold pack > 2 packs/28 days
- ☐ Bonjesta (doxylamine/pyridoxine extended-release)
- ☐ doxylamine/pyridoxine delayed-release
- ☐ Emend (aprepitant 125 mg powder for oral suspension) > 6 units/28 days
- ☐ granisetron tablet
- ☐ ondansetron 24 mg tablet
- ☐ ondansetron solution
- ☐ palonosetron 0.25 mg/2 mL injection > 2 units/28 days
- ☐ palonosetron 0.25 mg/5 mL injection > 2 units/28 days
- ☐ Sancuso (granisetron transdermal system)
- ☐ scopolamine transdermal patch
- ☐ Sustol (granisetron extended-release injection) > 2 units/28 days
- ☐ Varubi (rolapitant) > 2 tablets or vials/28 days
- ☐ Zuplenz (ondansetron film)

Dose, frequency and duration of requested medication _____

Indication (Check all that apply.)

- ☐ Chemotherapy-induced nausea and vomiting (CINV)
- ☐ Hyperemesis gravidarum
- ☐ Postoperative nausea and vomiting (PONV)
- ☐ Prevention of nausea and vomiting due to motion sickness
- ☐ Radiation-induced nausea and vomiting (RINV)
- ☐ Other _____

Section I. Please complete for Anzemet and granisetron tablet requests.

Has the member had a trial of ondansetron?

☐ 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, 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 scopolamine transdermal patch requests.

1. Does the member have a medical necessity for use of a transdermal patch formulation?
   ☐ Yes. (Please explain.) _____ ☐ No
2. Has the member had a trial with other medications for the treatment of this condition?
   ☐ Yes. Please list the drug name, dates/duration of trial, and outcomes below.
   Drug _____ 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.) _____

over

Section VII. 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 VIII. 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 _____