



Prior Authorization Form

Cesamet®

ONLY COMPLETED REQUESTS WILL BE REVIEWED

Drug Requested: (check one) [] Cesamet® [] Other (specify) _____

Dose _____ * Quantity _____

Date: _____ Patient ID#: _____ DOB: _____

Patient Name: _____ Provider NPI: _____

Prescribing Physician: _____ Office Contact: _____

Office Fax #: _____ Office Phone: _____

* Cesamet is limited to 6 units per prescription (specific to Medicare only)

ONLY COMPLETED REQUESTS WILL BE REVIEWED

1. DIAGNOSIS FOR DRUG REQUESTED:

- [] Chemotherapy-induced nausea and vomiting
[] Other (specify) _____

2. MEDICATION HISTORY (Please list any previous or current therapy related to the diagnosis, using drug names and dates)

[] N/A If none or not applicable to diagnosis, indicate "N/A."

Table with 3 columns: Drug Name, Date, Duration. Includes horizontal lines for data entry.

3. PATIENT HISTORY:

- a. Has the patient tried and failed an ondansetron containing product (Zofran®)? [] Yes [] No
b. Has the patient tried and failed granisetron (Kytril®)? [] Yes [] No
c. Has the patient tried and failed aprepitant (Emend®)? [] Yes [] No

Please add any other supporting medical information that may be useful in the decision-making process:

Horizontal lines for additional medical information.

FAX TO (888) 671-5285. YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL.

Internal use only section with fields for Document #, Coverage effective date, Processor Initials, Date, M F Rx coverage, Y N, STANDARD - SELECT, LOB, Previous Auth, Y N, Approved, Reviewer Initials, Date.