Prior Authorization Request Form
Non-formulary Antiemetic

SENSITIVE BUT UNCLASSIFIED

This form is to be completed and signed by the CCE Medical Director and should only be used for prescriptions to be filled through the World Trade Center Health Program (WTCHP).

The CCE should upload this completed form into VitalPoint and inform the PBM and the WTCHP of this request via the SAMS messaging system.

This form is to be used for these non formulary drugs: Anzemet (dolasetron), Aloxi (palonosetron), Sancuso transdermal patch (granisetron), Zuplenz oral soluble film (ondansetron), Varubi (rolapitant), Akynzeo (netupitant/palonsetron), Cesamet (nabilone), Marinol, Syndros (dronabinol), Trimethobenzamide (Tigan).

Please provide the following member and prescriber information (please print):

Member Name: _____ Prescriber Name: _____

Member ID: _____ Prescriber Address: _____

CCE: _____ _____

Requested Medication: _____ Prescriber Phone #: _____

Please complete the following clinical assessment:

1. Has the patient previously responded to a non-formulary medication and changing to a formulary medication would introduce unacceptable clinical risk(s) to the member?

Has the member filled at least one formulary medications listed below?

1. Use of formulary medication(s) is contraindicated (e.g., due to a hypersensitivity reaction)
2. Member has experienced or is likely to experience significant adverse effects from formulary medication(s).
3. Use of formulary medication(s) has resulted in a therapeutic failure.

Formulary Drugs

Kytril (granisetron); 1 mg tablet; oral soln	○1 ○2 ○3	☐ Yes **Sign and date below**	☐ No **Coverage not approved Proceed to question 2 if applicable**
Zofran (ondansetron); 4, 8 mg tablet, ODT, oral soln	○1 ○2 ○3		
Emend (aprepitant); 40, 80, 125 mg capsule	○1 ○2 ○3		

2. **Zuplenz request ONLY** – the patient requires a non-swallow dosage form AND has PKU (phenylketonuria) [Zuplenz does not contain phenylalanine - Zofran ODT contains phenylalanine]

☐ Yes **Sign and date below**

☐ No **Coverage not approved**

TO BE FILLED OUT BY WTC HEALTH PROGRAM

Decision:

Decision Comments:

By signing below, I certify that the above information is correct and accurate to the best of my knowledge.

_____ _____

WTCHP (NIOSH) Signature Date

_____ _____

CCE/NPN Medical Director (or Designee) Signature Date

Additional information may be attached to this document if needed.

Effective 6/20/2018

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