VIVA MEDICARE

417 20th Street North Suite 1100
Birmingham, AL 35203
Fax Number: (205) 449-2465

ORAL ANTI-EMETIC COVERAGE DETERMINATION FORM

Zofran® (ondansetron), Marinol® (dronabinol), Cesamet® (nabilone), Kytril®/Granisol® (granisetron)

*****Please Note Any Incomplete or Illegible Information Will Delay the Review Process*****

Patient Information:	Prescriber Information:
Patient Name:	Physician:
Member ID #:	Office Phone #:
Date of Birth:	Office Fax #:
Phone #:	DEA #:
Address:	Office Contact:

Medication and Diagnosis Information:		
Medication:		Strength:
Route:	Frequency:	Quantity:

Coverage Criteria Questions:		
ICD Code/Diagnosis:		
1. Is this medication related to a cancer chemotherapeutic regimen?	Yes	No
2. Is this medication being used as a full therapeutic replacement for an IV anti-emetic immediately before, after or within 48 hours of cancer therapy?	Yes	No
3. Were items 1 & 2 indicated on the prescription by the prescribing physician?	Yes	No
Additional Comments:		

Request Type:	Required Information:
☐ **Prior Authorization**	**View Prior Authorization & Step Therapy Criteria at:** **www.vivamedicaremember.com/Resource/Current/Formulary.aspx**
☐ **Quantity Exception:**	Request for an exception to the plan's limit on the number of pills available per month. The prescriber must provide clinical documentation that the restricted dose has been found to be ineffective and all other formulary alternatives have been found to be, or based on sound clinical judgment would likely be, ineffective.
☐ **Tier Exception:**	Request for an exception to the tier level for a covered drug. The prescriber must provide information that the drug in the lower-cost sharing tier for the treatment of the member's condition was tried and failed, is contraindicated, or would not be as effective as the drug in the higher cost-sharing tier or would have adverse effects. Limitations: Cannot request a tier exception for Tier 5 Specialty medications, or brand medications for generic tier cost-sharing, or for drugs approved as a formulary exception.

Rationale for Request: (Required)
Prescriber's Signature: **Date:**
Prescriber's Specialty:

Request for Expedited Review:
☐ By checking this box, I certify that waiting 72 hours for a standard review may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.
For Urgent Requests Needed Within 24 Hours Please Provide an After-Hours Contact and Direct Phone Number: _____