Coverage Determination Request Form – Oral Anti-Emetic Drugs (Medicare B vs. D)

This request is: ☐ **Expedited* (Urgent)** ☐ **Standard** (**Non-Urgent)**

*Expedited means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Please note: All information below is required to process this request. Any information that is incomplete or illegible will delay the review process.

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Member Insurance ID #:			NPI # :		Specialty:
Date of Birth:			Office Phone:		
Member Phone:			Office Fax:		
Member Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:

Medication Information (required)

Indicate Medication Requested: (NOTE: Drugs below are a representative list, only. See plan formulary to verify coverage status.)

☐ aprepitant (EMEND)
☐ dronabinol (MARINOL)
☐ nabilone (CESAMET)
☐ ondansetron (ZOFRAN)
☐ other _____
☐ dolasetron mesylate (ANZEMET)
☐ granisetron (KYTRIL, GRANISOL)
☐ netupitant / palonosetron (AKYNZEO)
☐ rolapitant (VARUBI)

Strength:	Dosage Form:
Quantity Prescribed:	Directions for Use:

B vs. D Primary Billing Determination (required)

☐ The requested antiemetic drug is not being used to treat Chemotherapy-Induced Nausea and Vomiting (CINV) **(*complete Part D Coverage Determination Criteria section below*)**

OR ☐ The requested antiemetic drug is being used for Chemotherapy-Induced Nausea and Vomiting (CINV) ***(complete the following questions)***

1. Is the patient receiving one of the following oral anti-cancer drugs: busulfan, capecitabine, cyclophosphamide, etoposide, melphalan, methotrexate, temozolomide, or topotecan?
   - ☐ YES (*Continue to Question 2*)
   - ☐ NO (*Continue to Question 4*)
2. Is the requested antiemetic drug used in conjunction with the oral anti-cancer drug due to the likelihood that it will otherwise induce emesis?
   - ☐ YES (*Continue to Question 3*)
   - ☐ NO ***(Complete Part D Coverage Determination Criteria section below)***

3. Is the requested antiemetic drug being administered within 2 hours before the oral anti-cancer drug is administered?

   ☐ YES **(*Bill to Medicare Part B*)**

   ☐ NO ***(Complete Part D Coverage Determination Criteria section below)***

4. Is the requested antiemetic drug being used as a full therapeutic replacement for an intravenous IV antiemetic drug that would otherwise have been administered at the time of chemotherapy treatment?

   ☐ YES (*Continue to Question 5*)

   ☐ NO ***(Complete Part D Coverage Determination Criteria section below)***

5. Is the requested drug being administered as part of oral antiemetic 3-drug combination of an NK-1 antagonist (such as Akynzeo, Emend, Varubi), a 5-HT3 antagonist (such as granisetron, ondansetron, etc.), and dexamethasone?

   ☐ YES (*Continue to Question 6*)

   ☐ NO ***(If for Akynzeo, Emend, or Varubi, Complete Part D Coverage Determination Criteria section below)***

   (If for other antiemetic drug, *Continue to Question 8*)

6. Is the patient receiving one or more of the following intravenous (IV) anti-cancer chemotherapeutic agents: alemtuzumab, azacitidine, bendamustine, carboplatin, carmustine, cisplatin, clofarabine, cyclophosphamide, cytarabine, dacarbazine, daunorubicin, doxorubicin, epirubicin, idarubicin, ifosfamide, irinotecan, lomustine, mechlorethamine, oxaliplatin, or streptozocin?

   ☐ YES (*Continue to Question 7*)

   ☐ NO ***(Complete Part D Coverage Determination Criteria section below)***

7. Is the IV chemotherapeutic regimen being administered in the home setting?

   ☐ YES ***(Complete Part D Coverage Determination Criteria section below)***

   ☐ NO (*Continue to Question 8*)

8. Will the administration of the requested antiemetic drug be initiated within two hours of the administration of the chemotherapeutic agent and continued for a period not to exceed 48 hours from that time [not to exceed **24** hours for granisetron (KYTRIL, GRANISOL) or dolasetron mesylate (ANZEMET)]?

   ☐ YES (*Continue to Question 9*)

   ☐ NO ***(Complete Part D Coverage Determination Criteria section below)***

9. Indicate route of administration for the patient's **first dose** of the requested drug:

   ☐ Oral **(*Bill to Medicare Part B*)**

   ☐ IV ***(Complete Part D Coverage Determination Criteria section below)***

Part D Coverage Determination Criteria (required)

The following requirements need to be met before this drug can be covered by the Part D plan. These requirements have been approved by the Centers for Medicare and Medicaid Services (CMS), but you may ask us for an exception if you believe one or more of these requirements should be waived.

Which condition is the drug being used for?

☐ Treatment of anorexia associated with weight loss in patients with AIDS **(DRONABINOL ONLY)**

☐ Indicate diagnosis: _____ ICD-10 Code (s): _____

Please Note: This drug is only covered under Medicare Part D when it is used for a medically accepted indication. A medically accepted indication is a use of the drug that is *either*:

- Approved by the Food and Drug Administration (FDA) – that is, that the FDA has approved the drug for the diagnosis or condition for which it is being prescribed.
- Supported by any of the following reference books – American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and/or the USPDI or its successor.

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other pertinent information the physician feels is important to this review? ☐ Yes ☐ No (If yes, please explain, below)

_____

_____

_____

Exception Requests (optional)

Do you believe one or more of the prior authorization requirements should be waived? ☐ Yes ☐ No

If yes, you must provide a statement explaining the medical reason why the exception should be approved.

Would this medication likely be the most effective option for this patient? ☐ Yes ☐ No

(If yes, please explain why, below)

_____

_____

_____

If the patient is currently using this medication, would changing the current regimen likely result in adverse effects for the patient? ☐ Yes ☐ No (If yes, please explain why, below)

_____

_____

_____

Submission Information (required)

Prescriber Signature: _____ **Date:** _____

Please Note:

- This request may be denied or dismissed unless all required information is received.
- Your office will receive a response via fax.
- For urgent requests, please call (866) 270-3877.
- For real time submission 24/7 please visit the secure prescriber portal on our plan's website for the appropriate form and instructions on how to submit your request.

Authorization Period: 1 Year - subject to formulary change and member eligibility.

PLEASE FAX COMPLETED FORM TO: 855-668-8552