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

Request Information (required)
This request is: ☐ **Expedited* (Urgent)** (decision within 24 hours) ☐ **Standard (Non-Urgent)** (decision within 72 hours) *If the requestor or prescriber believe that waiting 72 hours for a standard decision could seriously harm the member's life, health, or ability to regain maximum function, an expedited (fast) decision can be requested. If the prescriber indicates that waiting 72 hours could seriously harm the member's health, a decision will automatically be made within 24 hours. If the prescriber's support for an expedited request is not obtained, the request will be reviewed to determine if a fast decision is required.

Please Note: All information below is required to process this request. Any information that is incomplete or illegible will delay the review process. If the request is asking for an EXCEPTION, the prescriber MUST provide a statement supporting the request and the request cannot be processed without one. Please submit all **FORMULARY EXCEPTION** requests on the standard **CMS COVERAGE DETERMINATION** form. Requests that are subject to Prior Authorization (or any other utilization management requirement), may require supporting information.

Member Information (required)			Prescriber Information (required)		
Member Name:			Prescriber 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:

Requestor Information (required if not requested by the member or prescriber)		
An individual other than the member or prescriber (such as a family member or friend) may make a request on behalf of the member provided that the individual is a representative. **Documentation must be attached** showing the individual's authority to represent the member (a completed Authorization of Representation Form CMS-1696 or a written equivalent). For more information on appointing a representative, contact the plan or 1-800-Medicare.		
Requestor Name:	Requestor Phone:	
Requestor Address:	Relationship to Member:	
City:	State:	Zip:

Please fill out the following information:

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

- ☐ aprepitant (EMEND) (Go to #2)
- ☐ dronabinol capsule (MARINOL) (Go to #2)
- ☐ dronabinol solution (SYNDROS) (Go to #2)
- ☐ nabilone (CESAMET) (Go to #2)
- ☐ ondansetron (ZOFRAN, ZUPLENZ) (Go to #2)
- ☐ dolasetron mesylate (ANZEMET) (Go to #2)
- ☐ granisetron (KYTRIL, GRANISOL) (Go to #2)
- ☐ netupitant / palonosetron (AKYNZEO) (Go to #2)
- ☐ rolapitant (VARUBI) (Go to #2)
- ☐ Other (Go to #2)

2. Quantity Prescribed: (Go to #3)

3. Dosage Form: (Go to #4)

4. Strength & Route of Administration: (Go to #5)

5. Directions for Use (include frequency and expected length of therapy): (Go to #6)

B vs. D Primary Billing Determination (required)

6. Is the requested antiemetic drug being used to treat Chemotherapy-Induced Nausea and Vomiting (CINV)?

- ◯ Yes (Go to #7)
- ◯ No **(*complete Part D Coverage Determination Criteria section below*)** (Go to #16)

7. Is the member receiving ONE (1) of the following oral anti-cancer drugs: busulfan, capecitabine, cyclophosphamide, etoposide, melphalan, methotrexate, temozolomide, or topotecan?

- ◯ Yes (Go to #8)
- ◯ No (Go to #10)

8. 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 (Go to #9)
- ◯ No ***(Complete Part D Coverage Determination Criteria section below)*** (Go to #16)

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

- ◯ Yes **(*Bill to Medicare Part B*)** (END)
- ◯ No ***(Complete Part D Coverage Determination Criteria section below)*** (Go to #16)

10. 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 (Go to #11)
- ◯ No ***(Complete Part D Coverage Determination Criteria section below)*** (Go to #16)

11. 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 (Go to #12)
- ◯ No ***(If for Akynzeo, Emend, or Varubi, Complete Part D Coverage Determination Criteria section below)*** (Go to #16)
- ◯ No ***(If for other antiemetic drug)*** (Go to #14)

12. Is the member 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 (Go to #13)
- ◯ No ***(Complete Part D Coverage Determination Criteria section below)*** (Go to #16)

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

- ◯ Yes ***(Complete Part D Coverage Determination Criteria section below)*** (Go to #16)
- ◯ No (Go to #14)

14. 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 ONE (1) of the following from that time:
    - 24 hours for dolasetron mesylate (ANZEMET), granisetron (KYTRIL, GRANISOL), netupitant/palonosetron (AKYNZEO), and rolapitant (VARUBI)
    - 72 hours for aprepritant (EMEND)
    - 48 hours for all other medications

    ◯ Yes (Go to #15)

    ◯ No ***(Complete Part D Coverage Determination Criteria section below)*** (Go to #16)

15. Indicate route of administration for the member's **first dose** of the requested drug:

    ◯ Oral **(*Bill to Medicare Part B*)** (END)

    ◯ IV ***(Complete Part D Coverage Determination Criteria section below)*** (Go to #16)

Part D Coverage Determination Criteria (required)

16. What condition is the drug being used for?

    ☐ Prescribed for the treatment of anorexia associated with weight loss in a member with acquired immune deficiency syndrome (AIDS). **(dronabinol (MARINOL / SYNDROS) ONLY)** (Go to #17)

    ☐ Other (Go to #17)

17. Provide primary diagnosis including ICD-10 Code(s): (Go to #18)

Information Gathering

18. Are there any other comments, diagnoses, symptoms, medications tried or failed (including dates of drug trials and results of previous drug trials), drug allergies and/or any other pertinent information the physician feels is important to this review? (If yes, please explain below)	○ Yes (Go to #19)	○ No (Go to #19)

Exception Requests (optional)

19. If the request is not for a prior authorization, please indicate the request type: (The prescriber MUST provide a statement supporting the request. Requests cannot be processed without one.)

- ☐ N/A - Not an exception request (Go to #26)
- ☐ The member has been using a drug that was previously included on the plan's list of covered drugs, but is being removed or was removed from the list during the plan year. (Go to #20)
- ☐ The request is for an exception to the plan's limit on the number of pills (quantity limit) the member can receive so that the member can get the number of pills the prescriber prescribed. (Go to #20)
- ☐ The drug plan charges a higher copayment for the drug the prescriber prescribed than it charges for another drug that treats the member's condition, and the member wants to pay the lower copayment. (Go to #20)
- ☐ The member has been using a drug that was previously included on a lower copayment tier, but is being moved to or was moved to a higher copayment tier. (Go to #20)
- ☐ The drug plan charged the member a higher copayment for a drug than it should have. (Go to #20)
- ☐ The member wants to be reimbursed for a covered prescription drug that they paid for out of pocket. (Go to #20)

20. Do you believe one or more of the prior authorization requirements should be waived? (If yes, you must provide a statement explaining the medical reason why the exception should be approved.)	○ Yes (Go to #21)	○ No (Go to #21)

21. Would this medication likely be the most effective option for this member? (If yes, please explain below)	○ Yes (Go to #22)	○ No (Go to #22)
22. Is the member currently being treated for the condition(s) requiring the requested drug? (If yes, please explain the member's current drug regimen for the condition(s) below)	○ Yes (Go to #23)	○ No (Go to #23)
23. If the member is currently using this medication, would changing the current regimen likely result in adverse effects for the member? (If yes, please explain below)	○ Yes (Go to #24)	○ No (Go to #24)
24. Are there any concerns for a drug interaction with the addition of the requested drug to the member's current drug regimen? (If yes, please explain the benefits despite the noted concern and the monitoring plan to ensure safety below)	○ Yes (Go to #25)	○ No (Go to #25)
25. Are there any FDA noted contraindications to the requested drug? (If yes, please explain the benefits despite the noted concern and the monitoring plan to ensure safety below)	○ Yes (Go to #26)	○ No (Go to #26)

Additional Information

26. Please provide any additional information we should consider (or attach any supporting documents): (END)

Submission Information (required)

Signature: _____ **Date:** _____

Please Note:

- This request may be denied or dismissed unless all required information is received.
- The prescriber's office will receive a response via fax.
- For urgent requests, please call the phone number listed below.
- 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.
- Requests can also be initiated via phone, or the form may be sent via fax or mail:

Phone Number: (866) 270-3877
Fax Number: (855) 668-8552
Mailing Address: ATTN: PRIOR AUTHORIZATION
P.O. Box 1039
Appleton, WI 54912-1039

Authorization Period: 1 Year

PLEASE FAX COMPLETED FORM TO: 855-668-8552

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