Prior Authorization Form

Zuplenz Post Limit

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS/Caremark at **1-888-836-0730**.
Please contact CVS/Caremark at **1-800-294-5979** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Zuplenz Post Limit.

Drug Name (select from list of drugs shown)
Zuplenz (ondansetron oral soluble film)

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician
Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1.	Is this request for Zofran, Zuplenz or ondansetron?	Y N
	[If no, then skip to question 4.]	
2.	Is the patient pregnant with the diagnosis of Hyperemesis Gravidarum and a documented risk for hospitalization?	Y N
	[If no, then skip to question 4.]	
3.	Has the patient experienced an inadequate treatment response, intolerance, or contraindication to TWO of the following medications: A) vitamin B6, B) vitamin B6 in combination with doxylamine, C) doxylamine/pyridoxine extended-release (Bonjesta), D) doxylamine/pyridoxine	Y N

	delayed-release (Diclegis), E) promethazine (Phenergan), F) trimethobenzamide (Tigan), G) metoclopramide (Reglan), H) diphenhydramine (Benadryl), I) dimenhydrinate (Dramamine)?	
	[No further questions.]	
4.	Is the patient receiving radiation therapy or moderate to highly emetogenic chemotherapy?	Y N

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date