



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Aloxi

Phone: 215-991-4300 Fax back to: 866-240-3712

HEALTH PARTNERS manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name: Member Number: Date of Birth: Group Number: Address: City, State, Zip: Member Phone:	Prescriber Name: Fax: Phone: Office Contact: NPI: State Lic ID: Address: City, State, Zip:
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Drug Name: Expedited/Urgent

Directions:

Patient belongs to (please check one): HEALTH PARTNERS KIDZPARTNERS

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign:
Q1. What is the requested duration of therapy? 12 months or less Greater than 12 months
Q2. Is the patient over the age of 18? Yes No
Q3. Is the patient receiving moderately emetogenic cancer chemotherapy? Yes No
Q4. If yes, please list chemotherapeutic agents.
Q5. Is the patient receiving highly emetogenic cancer chemotherapy? Yes No
Q6. If yes, please list chemotherapeutic agents.
Q7. Is this medication prescribed to prevent postoperative nausea and vomiting for up to 24 hours following surgery? Yes No
Q8. Has the patient tried and failed or intolerant to formulary preferred Selective 5-HT3 Receptor Antagonist such as ondansetron (Zofran)? Yes No

Physician Signature

Date