

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

ALOXI (palonosetron hcl)

Patient name: _____ Medicaid or SS# _____

Physician Name: _____ Contact person: _____

Phone#: _____ Ext. and opt. _____ Fax# _____

Pharmacy _____ Pharmacy Phone#: _____

All information to be legible, complete and correct or form will be returned

**FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF
MEDICAL NECESSITY TO (801) 536-0477**

CRITERIA:

- ▶ Prevention of acute or delayed nausea and vomiting associated with initial and repeat courses of moderately emetogenic cancer chemotherapy
- ▶ Must have failed on Zofran, Anzemet or Kytril (5-HT3's)
- ▶ No other 5-HT3 medications allowed as rescue drugs

AUTHORIZATION:

6 months

RE-AUTHORIZATION:

Repeat course of chemotherapy following initial 6 months requires new authorization