

UTAH DEPARTMENT OF HEALTH PRIOR AUTHORIZATION REQUEST FORM

ZOFRAN (ondansetron hcl), **KYTRIL**(granisetron), **ANZEMET**(dolestron mesylate)

Patient name: _____ Medicaid or SS# _____

Physician Name: _____ Contact person: _____

Phone#: _____ Ext and options _____ Fax# _____

Pharmacy _____ Pharmacy Phone#: _____

Diagnosis _____ Medication _____

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

CRITERIA FOR PREGNANCY:

FAX DOCUMENTATION FROM PROGRESS NOTES TO (801) 536-0477

- ▶ **Pregnancy** related hyper-emesis exceeding 1 week
- ▶ Failure to respond to other medications including at least a trial of pyridoxine, and phenothiazines for current pregnancy **and/or**
- ▶ Has received IV re-hydration with imminent hospital admission if vomiting cannot be otherwise controlled

RE-AUTHORIZATION FOR PREGNANCY

Review and approval required by Drug Utilization Review Board

CRITERIA FOR CHEMO, RADIATION THERAPY, AND POST-OP NAUSEA:

TELEPHONE AUTHORIZATION (801) 538-6155

- ▶ Prevention of hyper-emesis associated with initial and repeat courses of **cancer treatment with chemotherapy**
- ▶ Prevention of hyper-emesis associated with **radiation therapy** in patients receiving either total body irradiation, single high-dose fraction to the abdomen, or daily fractions to the abdomen.
- ▶ Prevention **post-op hyper-emesis**

RE-AUTHORIZATION:

Telephone request from doctors office