OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Anzemet®, granisetron, Zofran® (ondansetron), Zofran ODT® (ondansetron orally disintegrating tablet [ODT]), Zuplenz® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

- ❑ Chemotherapy-induced nausea and vomiting
- ❑ Nausea and vomiting due to pregnancy (i.e., hyperemesis gravidarum) [for **Zofran (ondansetron), Zofran ODT (ondansetron ODT), Zuplenz** only]
- ❑ Nausea and vomiting due to radiotherapy (total body irradiation, single high-dose fraction to the abdomen, or daily fractions to the abdomen)
- ❑ Prevention of postoperative nausea and/or vomiting
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Select the medications the patient has a failure, contraindication, or intolerance to:

- ❑ Doxylamine
- ❑ Metoclopramide (Reglan)
- ❑ Prochlorperazine (Compazine)
- ❑ Promethazine (Phenergan)
- ❑ Pyridoxine (Vitamin B6)

Quantity limit requests:

What is the quantity being requested per MONTH: _____

Is the patient receiving moderately to highly emetogenic chemotherapy? ❑ **Yes** ❑ **No**

Has the patient had at least a partial response to therapy at a dose within the quantity limit? ❑ **Yes** ❑ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.