



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)
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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:
<input type="checkbox"/> Check if requesting brand		Directions for Use:	
<input type="checkbox"/> 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.

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