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

Akynzeo® Prior Authorization Request Form

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

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
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:

❑ Used for prevention of nausea and vomiting associated with cancer chemotherapy
❑ Other diagnosis: _____ ICD-10 Code(s): _____

Part B vs D questionnaire:

Will Akynzeo be initiated within 2 hours of administration of chemotherapy AND continued for a period not to exceed 48 hours from that time? ❑ **Yes** ❑ **No**

Will Akynzeo be used as a full therapeutic replacement for intravenous (IV) anti-emetic therapy that would have been administered at the time of the cancer chemotherapy treatment? ❑ **Yes** ❑ **No**

Will Akynzeo be used in combination with dexamethasone? ❑ **Yes** ❑ **No**
If yes, is the dexamethasone formulation oral? ❑ **Yes** ❑ **No**

Medication history:

Does the patient have a history of failure, contraindication, or intolerance to aprepitant or Emend used ***in combination*** with granisetron, ondansetron, or ondansetron orally disintegrating tablet (ODT)? ❑ **Yes** ❑ **No**

Does the patient have a history of failure, contraindication, or intolerance to a generic antiemetic not mentioned above? ❑ **Yes** ❑ **No**

Quantity limit requests:

What is the quantity requested per MONTH? _____

What is the reason for exceeding the plan limitations?

❑ Titration or loading-dose purposes
❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
❑ Requested strength/dose is not commercially available
❑ There is a medically necessary justification why the patient cannot use a higher commercially available strength to achieve the same dosage and remain within the same dosing frequency. **Please specify**: _____
❑ Other: _____

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.
If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.
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.