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

Granisetron tablet 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:

- ❑ Prevention of post-operative nausea and/or vomiting (when administered prior to induction of anesthesia)
- ❑ Prevention or treatment of nausea and vomiting associated with cancer chemotherapy
- ❑ Prevention or treatment of nausea and vomiting associated with radiotherapy (total body irradiation, single high-dose fraction to the abdomen, or daily fractions to the abdomen)
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

If the patient has End-Stage Renal Disease (ESRD), select all that apply:

- ❑ The medication is being used to treat/prevent nausea and vomiting secondary to dialysis
- ❑ The dialysis provider (i.e., nephrologist, nurse practitioner, physician assistant, or dialysis center) receives a monthly capitation payment to manage the ESRD patient's care

Part B vs D questionnaire:

Will this anti-emetic 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 this anti-emetic 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**

Quantity limit requests:

What is the quantity being requested per month: _____

Treatment cycles of chemotherapy OR radiotherapy:

Number of treatments per cycle: _____ Number of cycles per month: _____

Prevention of post-operative nausea and/or vomiting:

Will the patient be undergoing more than one surgical procedure in any one month period? ❑ **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.
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.