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

Varubi® Prior Authorization Request Form (Page 1 of 2)

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 delayed chemotherapy-induced nausea and vomiting (CINV)
❑ Other diagnosis: _____ ICD-10 Code(s): _____

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**

Clinical information:
Will Varubi be used in combination with other antiemetic agents? ❑ **Yes** ❑ **No**

Select the medications the patient has a failure, contraindication, or intolerance to:
❑ Aprepitant
❑ Emend
❑ Other generic anti-emetic (e.g., meclizine, promethazine)

Select the anti-cancer chemotherapeutic agents the patient is receiving:
❑ Carmustine
❑ Cisplatin
❑ Cyclophosphamide
❑ Dacarbazine
❑ Doxorubicin
❑ Epirubicin
❑ Lomustine
❑ Mechlorethamine
❑ Streptozocin
❑ Other(s). Please specify: _____

Is the patient **concurrently on** dexamethasone **AND** a 5-HT3 receptor antagonist (e.g., Anzemet [dolasetron], granisetron, Zofran [ondansetron])? ❑ **Yes** ❑ **No**

Will Varubi be **used in combination** with an oral 5-HT3 antagonist (e.g., Anzemet [dolasetron], granisetron, Zofran [ondansetron]) **AND** oral dexamethasone? ❑ **Yes** ❑ **No**

Varubi® Prior Authorization Request Form (Page 2 of 2)

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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.