



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

Oral Zofran[®] (oral ondansetron), Zofran ODT[®] (ondansetron ODT), Zuplenz[®] Prior Authorization Request Form (Page 1 of 2)

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

Member Information <small>(required)</small>			Provider Information <small>(required)</small>		
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 <small>(required)</small>					
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 <small>(required)</small>					
Select the diagnosis below: <input type="checkbox"/> Prevention of post-operative nausea and/or vomiting (when administered prior to induction of anesthesia) <input type="checkbox"/> Prevention or treatment of nausea and vomiting associated with cancer chemotherapy <input type="checkbox"/> 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) <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____					
If the patient has End-Stage Renal Disease (ESRD), select all that apply: <input type="checkbox"/> The medication is being used to treat/prevent nausea and vomiting secondary to dialysis <input type="checkbox"/> 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 <u>initiated</u> within 2 hours of administration of chemotherapy AND continued for a period <u>not to exceed 48 hours</u> from that time? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No					
For brand Zofran, brand Zofran ODT, or Zuplenz requests, select the medications the patient has a failure, contraindication, or intolerance to: <input type="checkbox"/> Granisetron <input type="checkbox"/> Ondansetron orally disintegrating tablet (ODT) <input type="checkbox"/> Ondansetron solution <input type="checkbox"/> Ondansetron tablet <input type="checkbox"/> Sancuso <input type="checkbox"/> Zofran <input type="checkbox"/> Zofran ODT <input type="checkbox"/> Other generic anti-emetic (e.g., meclizine, promethazine)					
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? <input type="checkbox"/> Yes <input type="checkbox"/> No					

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of OptumRx. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**

Office use only: Zofran-ondansetron-Zuplenz_CMS_2019Jan1-W



**Oral Zofran[®] (oral ondansetron), Zofran ODT[®] (ondansetron ODT),
Zuplenz[®] Prior Authorization Request Form (Page 2 of 2)**
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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.