QHP
Quality Health Plans of New York
A Medicare Advantage Plan

Attention: ACTION REQUESTED
Prior Authorization DENIAL may occur unless complete information is provided

Reference: [PA#]

General Prior Authorization Form: Oral Anti-Emetics

FAX COMPLETED FORM TO QHP PHARMACY DEPT. Fax # 877-817-0842

Coverage Criteria (guidance for Question 1 taken from Medicare Prescription Drug Benefit Manual, "Chapter 6-Appendix C-Summary of Coverage Policy" Attachment 1):

-Covered Uses: Subject to Part B vs. Part D review.

Member Information	Prescriber Information	
Patient Name:	Prescriber Name:	
Member ID#	NPI or DEA#:	
DOB:	Office Phone:	Office Fax:
Address:	Address:	
Home Phone:	Contact Person:	

Medication Information	Medical Information
Medication Requested (drug name, strength and route of administration):	Drug Allergies:
Medication Details (frequency, quantity):	Diagnosis:
Expected Length of Therapy:	Prescriber's Signature/Date:

Rationale for Prior Authorization

1. Is the anti-emetic being requested for cancer treatment and a full replacement for intravenous administration within 48 hours of cancer treatment? (check one) ___Yes (Part B) ___No (Part D)

- If **YES**, CMS currently requires that the prescribing physician indicate on the prescription that the oral anti-emetic is being used "as a full therapeutic replacement for an intravenous anti-emetic drug as part of a cancer chemotherapeutic regimen."

2. Please list other medications attempted for this patient:

Medication:	Reason therapy failed:	Length of therapy:
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. Additional comments: _____
_____

4. PLEASE INCLUDE RELEVANT MEDICAL RECORDS AND LAB REPORTS WITH YOUR REQUEST.

For Expedited Requests please call 1-877-233-7058
Our Formulary List is located at http://www.qualityhealthplansny.com

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