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United Healthcare Community Plan

COMMONWEALTH OF VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Service Authorization (SA) Form

ANTIEMETIC/ANTIVERTIGO MEDICATIONS

If the following information is not complete, correct, or legible, the SA process can be delayed.
Please use one form per member.

MEMBER INFORMATION

Last Name: _____

First Name: _____

Medicaid ID Number: _____

Date of Birth: _____

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Last Name: _____

First Name: _____

NPI Number: _____

Phone Number: _____

Fax Number: _____

DRUG INFORMATION

Does not require SA: ondansetron (ODT 4 mg and 8 mg /tablet/solution) (maximum quantity per fill = 60 for ODT/tablet); meclizine; metoclopramide (tablet/solution); prochlorperazine (tablet); promethazine in members over 2 years of age.

Drug Name/Form: _____

Strength: _____

Dosing Frequency: _____

Length of Therapy: _____

Quantity per Day: _____

(Form continued on next page.)

Member's Last Name: **Member's First Name:**

DIAGNOSIS AND MEDICAL INFORMATION

1. Does the member have a diagnosis of severe, chemotherapy-induced nausea and vomiting?
   ☐ Yes ☐ No
2. If the member's diagnosis is acquired immunodeficiency syndrome (AIDS)-related wasting, has the member tried and failed megestrol acetate oral suspension **or** does the member have a contraindication, intolerance, or drug-drug interaction?
   ☐ Yes ☐ No
3. Does the member have nausea or vomiting related to radiation therapy, moderate to highly emetogenic chemotherapy, or post-operative nausea and vomiting?
   ☐ Yes ☐ No
4. Has the member tried and failed therapeutic doses of, or had adverse effects or contraindications to, **two** different conventional antiemetics (e.g., promethazine, prochlorperazine, meclizine, metoclopramide, dexamethasone)?
   ☐ Yes ☐ No
5. Does the member have hyperemesis (i.e., pregnancy-related nausea/vomiting)?
   ☐ Yes ☐ No
6. Does the member have diabetic gastroparesis? If yes, list why oral metoclopramide can not be used.
   ☐ Yes ☐ No

   _____
7. What clinical evidence can be provided that the preferred agent(s) will not provide adequate benefit, what pharmaceutical agents were attempted, and what were the outcomes?

   _____

For ondansetron 16 mg ODT:

8. Has the member tried and failed or been intolerant to ondansetron 8 mg ODT?
   ☐ Yes ☐ No

(Form continued on next page.)

Member's Last Name: **Member's First Name:**

Prescriber Signature (Required) **Date**

By signature, the Physician confirms the above information is accurate and verifiable by member records.

Please include ALL requested information; Incomplete forms will delay the SA process.

Submission of documentation does NOT guarantee coverage by the Department of Medical Assistance Services.

Fax this form to 1-866-940-7328

Pharmacy PA call center: 1-800-310-6826