Jefferson Health Plans

# MEDICAID / CHIP

***PHARMACY PRIOR AUTHORIZATION REQUEST FORM***

## Antiemetics - Antivertigo Agents

**Phone: 866-841-7659** **Fax back to: 866-240-3712**

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

**PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL DELAY the review process.**

| | | |
|---|---|---|
| Member Name: | Prescriber Name: | |
| Member ID Number: | Fax: | Phone: |
| Date of Birth: | Office Contact: | |
| Member Phone Number: | NPI: | *PA PROMISe ID:* |
| Address: | Address: | |
| City, State ZIP: | City, State ZIP: | |
| Line of Business: ☐ Medicaid ☐ CHIP | *Specialty Pharmacy (if applicable):* | |
| **Drug Name:** | **Strength:** | |
| **Quantity:** | **Refills:** | |
| **Directions:** | | |
| **Diagnosis Code:** | **Diagnosis:** | |

*Jefferson Health Plans' maximum approval time is 12 months but may be less depending on the criteria..*

**Please attach any pertinent medical history including labs and information for this member that may support approval.**

***Please answer the following questions and sign.***

Q1. Is the requested drug being prescribed for the treatment of a diagnosis that is indicated in the Food and Drug Administration (FDA) approved package labeling or a medically accepted indication?

☐ Yes ☐ No

Q2. Is this a request for promethazine?

☐ Yes ☐ No

Q3. Is the patient 6 years of age or older?

☐ Yes ☐ No

Q4. Is the patient experiencing acute episodes of nausea and/or vomiting?

☐ Yes ☐ No

Q5. Is the patient at risk for emergency department/hospital admission for dehydration?

☐ Yes ☐ No

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Q6. Has the patient demonstrated therapeutic failure, contraindication to or intolerance of oral rehydration therapy?

☐ Yes ☐ No

Q7. Has the patient demonstrated therapeutic failure, contraindication to or intolerance of alternative pharmacologic treatments, such as ondansetron?

☐ Yes ☐ No

Q8. Will the patient be taking the requested drug concomitantly with a medication with respiratory depressant effects, including cough and cold medications?

☐ Yes ☐ No

Q9. Does the patient have a history of contraindication to the requested drug?

☐ Yes ☐ No

Q10. Have the patient's nausea and vomiting symptoms been present for more than one week?

☐ Yes ☐ No

Q11. Has the patient had a documented evaluation for causes of persistent nausea and/or vomiting?

☐ Yes ☐ No

Q12. Is this a request for a preferred antiemetic-antivertigo agent?

☐ Yes ☐ No

Q13. Is this a request for a non-preferred oral serotonin receptor antagonist?

☐ Yes ☐ No

Q14. Does the patient have a documented history of therapeutic failure, contraindication to, or intolerance of the preferred oral serotonin receptor antagonists?

☐ Yes ☐ No

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Q15. Is this a request for a non-preferred non-oral serotonin receptor antagonist?

☐ Yes ☐ No

Q16. Does the patient have a documented history of therapeutic failure, contraindication to, or intolerance of the preferred non-oral serotonin receptor antagonists?

☐ Yes ☐ No

Q17. Is this a request for a non-preferred oral neurokinin-1 receptor antagonist?

☐ Yes ☐ No

Q18. Does the patient have a documented history of therapeutic failure, contraindication to, or intolerance of the preferred oral neurokinin-1 receptor antagonists?

☐ Yes ☐ No

Q19. Is this a request for a non-preferred non-oral neurokinin-1 receptor antagonist?

☐ Yes ☐ No

Q20. Does the patient have a documented history of therapeutic failure, contraindication to, or intolerance of the preferred non-oral neurokinin-1 receptor antagonists?

☐ Yes ☐ No

Q21. Does the patient have a documented history of therapeutic failure, contraindication to, or intolerance of the preferred antiemetic antivertigo agents approved or medically accepted for the patient's diagnosis?

☐ Yes ☐ No

Q22. Additional Information:

Prescriber Signature

Date

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*v2026-06*