

Request for Prior Authorization for Substance P Neurokinin-1 (NK1) Receptor Antagonists
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

All requests for substance P neurokinin-1 (NK1) receptor antagonists require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Substance P Neurokinin-1 (NK1) Receptor Antagonists Prior Authorization Criteria:

For all requests for substance P neurokinin-1 (NK1) receptor antagonists all of the following criteria must be met:

- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines
- Is age-appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature
- Documentation the member is not taking pimozide.

Coverage may be provided for the prevention of acute and delayed nausea and vomiting associated with chemotherapy and the following criteria is met:

- Documentation the member is receiving highly emetogenic cancer chemotherapy (HEC) including high-dose cisplatin or moderately emetogenic cancer chemotherapy (MEC).
- Documentation the medication will be used in combination with other antiemetic agents.
- **Duration of Approval:** 12 months

Coverage may be provided with a diagnosis of postoperative nausea and vomiting and the following criteria is met (emend capsules only):

- Must provide documentation showing the member has tried and failed (which will be verified via pharmacy claims if available) or had an intolerance or contraindication to ondansetron.
- **Duration of Approval:** 3 months

**SUBSTANCE P NEUROKININ-1 (NK1) RECEPTOR ANTAGONISTS
PRIOR AUTHORIZATION FORM**

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX:** (855) 476-4158
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (844) 325-6253 Monday through Friday 8:30am to 5:00pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:
Health Options ID:	Member weight: _____ pounds or _____ kg

REQUESTED DRUG INFORMATION

Medication:	Strength:
Frequency:	Duration:
Is the member currently receiving requested medication? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date Medication Initiated: _____	
Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Billing Information

This medication will be billed: at a pharmacy **OR**
 medically (if medically please provide a JCODE: _____)

Place of Service: Hospital Provider's office Member's home Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Diagnosis :

Acute and delayed nausea and vomiting associated with chemotherapy

Postoperative nausea and vomiting

Other: _____

Is the member currently on pimozide? Yes No

For members with acute and delayed nausea and vomiting associated with chemotherapy

- Will the member be using the requested medication in combination with another antiemetic agent? Yes No
- Is the member receiving highly emetogenic chemotherapy (HEC) or moderately emetogenic chemotherapy (MEC)?
 Yes No

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature

Date

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Updated: 10/2019
DMMA Approved: 10/2019