Updated: 10/2019
DMMA Approved: 10/2019

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

HIGHMARK. Delaware HEALTH OPTIONS

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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) 325-6251 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? ☐ Yes ☐ 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? ☐ Yes ☐ 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

1. Will the member be using the requested medication in combination with another antiemetic agent? ☐ Yes ☐ No

2. 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