Gateway Health Plan
Pharmacy Division
Phone 800-392-1147 Fax 888-245-2049

I. Requirements for Prior Authorization of Antiemetic/Antivertigo Agents

A. Prescriptions That Require Prior Authorization

Prescriptions for Antiemetic/Antivertigo Agents that meet the following conditions must be prior authorized:

1. A non-preferred Antiemetic/Antivertigo Agent. See the Preferred Drug List (PDL) for the list of preferred Antiemetic/Antivertigo Agents at: https://papdl.com/preferred-drug-list.

2. A prescription for promethazine for a child under 6 years of age.

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for an Antiemetic/Antivertigo Agent, the determination of whether the requested prescription is medically necessary will take into account whether the beneficiary:

1. Is being prescribed the Antiemetic/Antivertigo Agent for an indication that is included in the U.S. Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication; **AND**

2. For a non-preferred Antiemetic/Antivertigo Agent, has a history of therapeutic failure, contraindication, or intolerance to the preferred Antiemetic/Antivertigo Agents approved or medically accepted for the beneficiary's diagnosis; **AND**

3. For promethazine for a child under 6 years of age, **all** of the following:

   a. Is experiencing acute episodes of nausea and/or vomiting,

   b. Is at risk for emergency department/hospital admission for dehydration,

   c. Has demonstrated therapeutic failure, contraindication, or intolerance to oral rehydration therapy,

   d. Has demonstrated therapeutic failure, contraindication, or intolerance to alternative pharmacologic treatments, such as ondansetron,

   e. Will not be taking promethazine concomitantly with a medication with respiratory depressant effects, including cough and cold medications,

   f. Has a documented evaluation for causes of persistent nausea and/or vomiting if symptoms have been present for more than one week,

   g. Does not have a history of a contraindication to the prescribed medication;

   NOTE: If the beneficiary does not meet the clinical review guidelines above but, in the professional judgement of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

Gateway Health Plan
Pharmacy Division
Phone 800-392-1147 Fax 888-245-2049

C. Clinical Review Process

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B. above to assess the medical necessity of a prescription for an Antiemetic/Antivertigo Agent. If the guidelines in Section B. are met, the reviewer will prior authorize the prescription. If the guidelines are not met, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary.

Gateway Health℠ It's Wholecare.

Gateway Health Plan
Pharmacy Division
Phone 800-392-1147 Fax 888-245-2049

NON-PREFERRED MEDICATION PRIOR AUTHORIZATION FORM

☐ **FOR ONCOLOGY USE**

☐ New request ☐ Renewal request	# of pages: _____	Prescriber name:
Name of office contact:	Specialty:	Office NPI:
Contact's phone number:	NPI:	State license #:
LTC facility contact/phone:	Street address:	
Beneficiary name:	Suite #:	City/State/Zip:
Beneficiary ID#: DOB:	Phone:	Fax:
Medication will be billed via: ☐ Pharmacy ☐ Medical (Jcode:)	Place of Service: ☐ Hospital ☐ Provider's Office ☐ Home ☐ Other	

Please refer to https://papdl.com/preferred-drug-list for the list of preferred and non-preferred medications in each Preferred Drug List class.

Non-preferred medication name:	Dosage form:	Strength:
Directions:	Quantity:	Refills:
Diagnosis *(submit documentation)*:	Dx code (*required*):	

Has the beneficiary taken the requested non-preferred medication in the past 90 days? *(submit documentation)*..... ☐ Yes ☐ No

Describe all applicable medical reasons the beneficiary cannot use the preferred medication(s) in the same Preferred Drug List class. *Submit documentation (e.g., recent chart/clinic notes, diagnostic evaluations, lab results, etc.) supporting this non-preferred request.*

☐ Treatment failure or inadequate response with preferred medication(s) *(include drug name, dose, and start/stop dates)*:

_____

_____

☐ Unacceptable side effects, hypersensitivities, or other intolerances to preferred medication(s) *(include description and drug name(s))*:

_____

_____

☐ Contraindication to preferred medication(s) *(include description and drug name(s))*:

_____

_____

☐ Unique clinical or age-specific indications supported by FDA approval or medical literature *(describe)*:

_____

_____

☐ Absence of preferred medication(s) with appropriate formulation *(list medical reason formulation is required)*:

_____

_____

☐ Drug-drug interaction with preferred medication(s) *(describe)*:

_____

_____

☐ Other medical reason(s) the beneficiary cannot use the preferred medication(s) *(describe)*:

_____

_____

☐ **For renewal requests of previously approved medications, submit documentation of tolerability and beneficiary's clinical response.**

PLEASE FAX COMPLETED FORM TO GATEWAY – PHARMACY DIVISION

Prescriber Signature:	**Date**: