Updated: 03/2019
PARP Approved: 03/2019

Gateway Health
Prior Authorization Criteria
**Aloxi (Palonosetron)**

All requests for Aloxi (Palonosetron) require a prior authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Aloxi (Palonosetron) Prior Authorization Criteria:

Coverage may be provided for the prevention of postoperative nausea and vomiting and the following criteria is met:

- The member must be 18 years of age or older
- 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
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines
- **Duration of Approval:** 3 months

Coverage may be provided for the prevention of chemotherapy-induced nausea and vomiting and the following criteria is met:

- The member must be 1 month of age or older
- Must meet one of the following:
    - If Aloxi will be used in combination with Dexamethasone without a Neurokinin 1 receptor antagonist, 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 Granisetron (may require prior authorization)
    - In all other antiemetic regimens, 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
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines
- **Duration of Approval:** 12 months

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

Updated: 03/2019
PARP Approved: 03/2019

# ALOXI (Palonosetron Hydrochloride) PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Gateway Health℠ Pharmacy Services. **FAX:** (888) 245-2049
If needed, you may call to speak to a Pharmacy Services Representative.
**PHONE**: (800) 392-1147 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: |
| Gateway 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: |

## 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:** _____ ICD-10 Code: _____

## CURRENT or PREVIOUS THERAPY

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

## REAUTHORIZATION

Has the member experienced a significant improvement with treatment? ☐ Yes ☐ No

## SUPPORTING INFORMATION or CLINICAL RATIONALE

| |
|---|
| |
| |
| |

| Prescribing Provider Signature | Date |
|---|---|
| | |