



Prior Authorization Form

**Arkansas Blue Cross and Blue Shield (Medicare)
Medi-Pak Rx (PDP) and Medi-Pak Advantage (PFFS)
Granisetron, Ondansetron Oral (Medicare B vs. D)**

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS|Caremark at 1-888-836-0730.
Please contact CVS|Caremark at 1-800-294-5979 with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Granisetron, Ondansetron Oral (Medicare B vs. D).

Drug Name (select from list of drugs shown)

Granisetron	Ondansetron ODT	Ondansetron Oral Solution
Ondansetron Tablet		

Patient Information

Patient
Name: _____
Patient ID: _____
Patient
Group No.: _____
Patient
DOB: _____

Prescribing Physician

Physician
Name: _____
Physician
Phone: _____
Physician
Fax: _____
Physician
Address: _____
City, State,
Zip: _____

Diagnosis: _____ ICD Code: _____

Please circle the appropriate answer for each applicable question.

1. Did the patient have any IV antiemetic doses at the time of chemotherapy? Y N
 [If the answer to this question is yes, then no further questions required.]
2. Is this drug being used as part of a cancer chemotherapy regimen? Y N
 [If the answer to this question is no, then no further questions required.]
3. Will the oral antiemetic formulation be used as a full therapeutic replacement for intravenous administration of the antiemetic drug within 48 hours of chemotherapy? Y N
 [If the answer to this question is no, then no further questions required.]
4. Will the patient require more than 48 hours (2 calendar days) of antiemetic therapy with this agent? Y N

Comments: _____

I affirm that the information given on this form is true and accurate as of this date.



**Arkansas
BlueCross BlueShield**

An Independent Licensee of the Blue Cross and Blue Shield Association

Prescriber (Or Authorized) Signature and Date