Prior Authorization Form

Sancuso Post Limit

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 Sancuso Post Limit.

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D	n Nama (a ala at fuana liat	of dwine ob acces		
	g Name (select from list	,		
Sar	ncuso (granisetron trans	dermai system)		
Qua	antity	Frequency	Strength	
Route of Administration		Expected Length of Therapy		
Pati	ent Information			
Patient Name:				
Pati	ent ID:			
Pati	ent Group No.:			
Pati	ent DOB:			
Pati	ent Phone:			
Pres	scribing Physician			
Phy	sician Name:			
Phy	sician Phone:			
Phy	sician Fax:		<u></u>	
Phy	sician Address:			
City	, State, Zip:		<u> </u>	
Dia	gnosis:	ICD Code:		
,	<u></u>			
Con	nments:			
Pleas	se circle the appropriate an			
1.	Is this request for Zofr	an, Zuplenz or ondansetron?	YN	
	[If no, then skip to q	uestion 4.]		
2.		t with the diagnosis of Hyperemes cumented risk for hospitalization?	is Y N	
	[If no, then skip to q	uestion 4.]		
3.	response, intolerance, following medications: combination with doxy	enced an inadequate treatment or contraindication to TWO of the A) vitamin B6, B) vitamin B6 in lamine, C) doxylamine/pyridoxine njesta), D) doxylamine/pyridoxine	YN	

	delayed-release (Diclegis), E) promethazine (Phenergan), F) trimethobenzamide (Tigan), G) metoclopramide (Reglan), H) diphenhydramine (Benadryl), I) dimenhydrinate (Dramamine)?		
	[No further questions.]		
4.	Is the patient receiving radiation therapy or moderate to highly emetogenic chemotherapy?		

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date				