

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

ALOXI (palonoson hcl)

Patient name: _____ Medicaid ID #: _____

Prescriber Name: _____ Prescriber NPI#: _____ Contact person: _____

Prescriber Phone#: _____ Extension/Option: _____ Fax#: _____

Pharmacy: _____ Pharmacy Phone#: _____ Pharmacy Fax #: _____

Requested Medication: _____ Strength: _____ Frequency/Day: _____

All information to be legible, complete and correct or form will be returned

**FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF
MEDICAL NECESSITY TO 855-828-4992 note the new fax number**

CRITERIA:

- ▶ Prevention of acute or delayed nausea and vomiting associated with initial and repeat courses of moderately emetogenic cancer chemotherapy.
- ▶ Must have failed on Zofran, Anzemet or Kytril (5-HT3's).
- ▶ No other 5-HT3 medications allowed as rescue drugs

AUTHORIZATION:

6 months

RE-AUTHORIZATION:

Repeat course of chemotherapy following initial 6 months requires new authorization

9/13/10

<http://health.utah.gov/medicaid/pharmacy>