



DATE _____

CLIENT _____

DRUG _____

PRIOR AUTH CRITERIA- 5-HT3 Nausea Agents

<i>M.D. Last Name:</i> _____	<i>M.D. First Name:</i> _____
<i>Physician Phone:</i> _____	<i>Physician Fax:</i> _____
<i>Patient</i> _____	<i>ID#</i> _____ <i>DOB</i> _____

TO ENSURE PROMPT PROCESSING PLEASE COMPLETE ALL OF THE QUESTIONS.

- | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|----|
| 1. Is the patient receiving emetogenic chemotherapy? (If NO, skip to #4) | Yes | No |
| 2. Chemo agents being used _____ | | |
| 3. How Often, or what is the cycle? _____
(When finished with #3 SKIP to #11) | | |
| 4. Does the patient have hyperemesis gravidarum? (If NO, Skip to #10) | Yes | No |
| 5. Is the patient in ketosis? | Yes | No |
| 6. Would I.V. therapy be necessary without the use of 5-HT3 agents? | Yes | No |
| 7. Is the patient vomiting despite adequate treatment with at least two of the following antiemetics?
dimenhydrinate, diphenhydramine, doxylamine, meclizine, metoclopramide (pregnancy risk category B). (PLEASE CIRCLE DRUGS THAT HAVE BEEN TRIED.) | Yes | No |
| 8. Has the patient had weight loss or failure to gain weight within the normal limits as expected?
How many weeks pregnant? _____ Weight gain (lbs)? _____ (STOP HERE) | Yes | No |
| 9. Other diagnosis or reason for nausea and vomiting _____ | | |
| 10. Has the patient tried and failed at least three (3) other non-5-HT3 receptor antagonist antiemetic agents, including but not limited to metoclopramide, prochlorperazine, promethazine, and thiethylperazine? (PLEASE CIRCLE DRUGS THAT HAVE BEEN TRIED) | Yes | No |
| 11. List any other antiemetics used: _____ | | |

Physician Signature or name of person providing answers _____

Physician Comments _____

Send or Fax completed form to:
877-329-7279

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