

Pharmacy Prior Authorization

AETNA BETTER HEALTH FLORIDA

Sancuso

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health Florida at **1-855-799-2554**.

When conditions are met, we will authorize the coverage of Sancuso.

Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(please circle)*

Sancuso (granisetron transdermal patch)

Other, please specify _____

Quantity _____

Frequency _____

Strength _____

Route of Administration _____

Expected Length of therapy _____

Patient Information

Patient Name: _____

Patient ID: _____

Patient Group No.: _____

Patient DOB: _____

Patient Phone: _____

Prescribing Physician

Physician Name: _____

Specialty: _____

NPI Number: _____

Physician Fax: _____

Physician Phone: _____

Physician Address: _____

City, State, Zip: _____

Diagnosis: _____ ICD Code: _____

Please circle the appropriate answer for each question.

1. Do progress notes support the patient is currently on chemotherapy and is experiencing chemotherapy-induced nausea/vomiting (CINV) or the patient is receiving moderately and/or highly emetogenic chemotherapy for up to 5 consecutive days?
[If no, then no further questions.] Y N
2. Do progress notes document the patient has had a trial and failure of a preferred agent?
[If no, then no further questions.] Y N

3. Does the patient have documentation of difficulty swallowing?

Y N

Comments:

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

Prescriber (Or Authorized) Signature

Date