

CESAMET

PRIOR AUTHORIZATION REQUEST FORM

Complete ENTIRE form and Fax to: 866-940-7328

SECTION A - PATIENT INFORMATION

Today's Date:	First Name:	Last Name:
Member ID #:	Address:	
City:	State:	Zip:
Phone:	DOB:	Allergies:
Primary Insurance:	Policy #:	Group #:

Is the requested medication **NEW** or a **CONTINUATION of THERAPY** ? If so, start date: _____

Is this patient currently hospitalized? Yes No

SECTION B - PHYSICIAN INFORMATION

First Name:	Last Name:	M.D./D.O.	
Address:	City:	State:	Zip:
Phone:	Fax:	NPI #:	Specialty:

Office Contact Name / Fax Attention to:

Medication:	Strength:
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Directions for use:

Diagnosis (Please be specific & provide as much information as possible):	ICD 10 Code:
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SECTION C - CLINICAL INFORMATION

Does the patient have a diagnosis of nausea and vomiting associated with cancer chemotherapy?

Yes **No**

Does the patient have a history of failure, contraindication, or intolerance to dronabinol (Marinol)

capsules? **Yes** **No**

If yes, provide dates of therapy: _____

Does the patient have a history of failure, contraindication, or intolerance to any of the following drugs? (check all that apply)

Zofran (ondansetron) Anzemet (dolasetron) Kytril (granisetron) Aloxi (palonosetron) Other _____

Does the patient have a history of failure, contraindication, or intolerance to any of the following drug classes? (check all that apply)

Antihistamines Corticosteroids Prokinetic Agents Antipsychotic Agents Benzodiazepines

Provide names of medications and dates of therapy: _____

Physician Signature: _____ **Date:** _____

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