

Please note: All information below is required to process this request.

Fax to 1-844-403-1029 Mon-Sat: 7am to 7pm Central

Zuplenz® Prior Authorization Request Form

| | DO NOT COPY F | OR FUTURE USE. FORMS | S ARE UPDATED FREQ | UENTLY AND MAY BE | BARCODED | |
|---|--------------------------------|----------------------|--------------------|---------------------------------|--------------|--|
| Member Information (required) | | | | Provider Information (required) | | |
| Member Name: | | | Provider Nan | Provider Name: | | |
| Insurance ID#: | | | NPI#: | | Specialty: | |
| Date of Birth: | | | Office Phone | Office Phone: | | |
| Street Address: | | | Office Fax: | Office Fax: | | |
| City: | State: | Zip: | Office Street | Office Street Address: | | |
| Phone: | | | City: | State: | Zip: | |
| Medication Information (required) | | | | | | |
| Medication Name: | | | Strength: | <u>`</u> | Dosage Form: | |
| ☐ Check if requesting brand | | | Directions fo | Directions for Use: | | |
| □ Check if reque | est is for continuation | of therapy | | | | |
| Clinical Information (required) | | | | | | |
| Clinical information: | | | | | | |
| Has the patient had a trial of a generic -Hydroxytryptamine type 3 (5-HT3) receptor antagonist for 14 days in the past 90 days? ☐ Yes ☐ No | | | | | | |
| Is the patient receiving moderately and/or highly emetogenic chemotherapy for up to 5 consecutive | | | | | | |
| days? ☐ Yes ☐ No | | | | | | |
| Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review? | | | | | | |
| | | | | | | |
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| Please note: This request may be denied unless all required information is received. For urgent or expedited requests please call 1-855-401-4262. This form may be used for non-urgent requests and faxed to 1-844-403-1029. | | | | | | |

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