Pharmacy Prior Authorization

MERCY CARE – TITLE 19/21 SMI (MEDICAID)

Ondansetron Oral Solution (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Mercy Care – Title 19/21 at **1-855-247-3677**.
When conditions are met, we will authorize the coverage of Ondansetron Oral Solution (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(circle drug)*

ondansetron oral solution

Other, specify drug _____

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:** _____

Circle the appropriate answer for each question.

1. Has the plan authorized this medication in the past for this member (i.e., previous authorization is on file under this plan)? Y N

   [If no, then skip to question 3.]

2. Has the member had a response to treatment? Y N

   [No further questions.]

3. Is the member 3 years of age or younger? Y N

   [If yes, then no further questions.]

4. Has the member had a trial of ondansetron tablet or ondansetron orally disintegrating tablet (ODT)? 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**