BlueCross BlueShield Federal Employee Program

5-HT3 ANTAGONISTS PRIOR APPROVAL REQUEST

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the provider portion and submit this completed form.

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: R			Physician Signature:		
PHYSICIAN COMPLETES					

5-HT3 Antagonists

NOTE: Form must be completed in its **entirety** for processing

Please select medication and indicate quantity:

❑**Aloxi (palonosetron)**	**quantity _____ mL(s) per 90 days**
❑**Anzemet 50mg tablet (dolasetron)**	**quantity _____ tablet(s) per 90**
❑**Anzemet 100mg tablet (dolasetron)**	**quantity _____ tablet(s) per 90**
❑**Granisetron injection**	**quantity _____ mL(s) per 90 days**
❑**Kytril 1mg tablet (granisetron)**	**quantity _____ tablet(s) per 90 days**
❑**Ondansetron ODT 16mg tablet**	**quantity _____ tablet(s) per 90 days**
❑**Ondansetron 24mg tablet**	**quantity _____ tablet(s) per 90 days**
❑ **Posfrea (palonosetron)**	**quantity _____ mL(s) per 90 days**
❑**Sancuso patch (granisetron)**	**quantity _____ patch(es) per 90 days**
❑**Sustol ER injection (granisetron)**	**quantity _____ syringe(s) per 90 days**
❑**Zofran 4mg/5mL suspension (ondansetron)**	**quantity _____ mL(s) per 90 days**
❑**Zofran injection (ondansetron)**	**quantity _____ mL(s) per 90 days**
❑**Zofran / Zofran ODT 4mg (ondansetron)**	**quantity _____ unit(s) per 90 days**
❑**Zofran / Zofran ODT 8mg (ondansetron)**	**quantity _____ unit(s) per 90 days**
❑**Zuplenz 4mg oral film (ondansetron)**	**quantity _____ unit(s) per 90 days**
❑**Zuplenz 8mg oral film (ondansetron)**	**quantity _____ unit(s) per 90 days**

***Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

****Non-covered branded medications must go through prior authorization and the formulary exception process**

Is this request for brand or generic? ❑Brand ❑Generic

1. Is the prescribing physician a board-certified oncologist? ❑Yes ❑No

2. What is the patient's diagnosis?
   - ❑Nausea and/or vomiting of pregnancy (NVP) (including Hyperemesis Gravidarum)
     a. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to another treatment such as vitamin B6 or doxylamine? ❑Yes ❑No
   - ❑Post-operative nausea and/or vomiting
     a. Was the patient's operation completed within the last month? ❑Yes ❑No
   - ❑Prevention of nausea and/or vomiting due to radiation or cancer chemotherapy
   - ❑Treatment of nausea and/or vomiting due to radiation or cancer chemotherapy
   - ❑Other diagnosis ***(please specify):*** _____

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification:** I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer. 5-HT3 Antagonists – FEP MD Fax Form Revised 8/1/2025