SANCUSO/GRANISOL/ZUPLENZ
PRIOR AUTHORIZATION

SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

SD Medicaid requires that patients receiving a new prescription for Sancuso, Granisol or Zuplenz must first try other anti-nausea medications.

- **Patients must use a generic 5-hydroxytryptamine-3 receptor antagonist or other anti-nausea medication for at least 14 days for the trial to be considered a failure.**
- **Patients must be receiving moderately and/or highly emetogenic chemotherapy for up to 5 consecutive days.**

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:		PHYSICIAN DEA NUMBER:
CITY:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug and Dosage: □ Sancuso _____ □ Granisol _____ □ Zuplenz _____	Patient able to tolerate oral medications: Failed medication _____ Was trial for at least 14 days? □ YES □ NO
□ Patient unable to tolerate oral medications (Sancuso only)	
PHYSICIAN SIGNATURE:	DATE:

Part IV: PHARMACY INFORMATION

PHARMACY NAME:	SD MEDICAID PROVIDER NUMBER:
PHONE: ( ):	FAX:: ( )
DRUG:	NDC#:

Part V: FOR OFFICIAL USE ONLY

Date: / /	Initials: _____
Approved - Effective dates of PA: From: / /	To: / /
Denied: (Reasons)	