PriorityHealth

Pharmacy Prior Authorization Form

Last Reviewed: July 2011

For Prior Authorization please fax to: (877)974-4411 toll free, or (616)942-8206

This form applies to: ☐ **Commercial Plan** ☐ **Medicaid Plan** ☒ **Medicare Plan**

Emend (aprepitant)

☐ Urgent ☐ Non-urgent

Member Name:	Member #:
DOB:	Gender:
Provider Name:	Provider Phone:
Provider Office Address:	
Provider Office Contact Name:	Provider Fax:
Provider Signature:	Provider NPI:
Date:	Member's PCP:

Product:

☐ Emend 40mg capsule ☐ Emend 125mg capsule

☐ Emend 80mg capsule ☐ Emend Tri-fold pack

Dose: ________________________________ Start date: ____________________

Priority Health Precertification Requirement:

Authorization of oral Emend requires:

- If prescribed in accordance with the National Coverage Determination for Emend, and is being used in combination with an **oral** 5-HT_3 receptor antagonist and **oral** dexamethasone, and one of the following anticancer chemotherapeutic agents was administered, it is considered a Medicare Part B benefit: carmustine, cisplatin, cyclophosphamide, dacarbazine, doxorubicin, epirubicin, lomustine, mechlorethamine, streptozocin.
- If prescribed for a medically accepted indication that is not covered under the National Coverage Determination for Emend or the Bifold Pack of Emend is being prescribed for use after Emend for injection, it is considered a Part D benefit.
- When approved, authorization will be limited to 6 capsules per 30 days

Please Complete the Following Information:

Diagnosis:

☐ Prevention of nausea/vomiting associated with moderately to highly emetogenic cancer chemotherapy

☐ Prevention of postoperative nausea/vomiting

☐ Other: ____

Please provide rationale for use: ____

Please select from the following:

☐ Patient is receiving an oral 5-HT_3 receptor antagonist

☐ Patient is receiving oral dexamethasone

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☐ Patient is receiving one of the following anticancer chemotherapeutic agents:

☐ carmustine	☐ cisplatin	☐ cyclophosphamide
☐ dacarbazine	☐ doxorubicin	☐ epirubicin
☐ lomustine	☐ mechlorethamine	☐ streptozocin

☐ Patient is receiving oral Emend for use after Emend for injection

*** All fields must be complete and legible for Prior Authorization Review***

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YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX