



Prior Authorization Form

**Arkansas Blue Cross and Blue Shield (Medicare)
Medi-Pak Rx (PDP) and Medi-Pak Advantage (PFFS)
Anzemet Oral (Medicare B vs. D)**

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS|Caremark at 1-888-836-0730.
Please contact CVS|Caremark at 1-800-294-5979 with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Anzemet Oral (Medicare B vs. D).

Drug Name (select from list of drugs shown)

Anzemet tablet(s)

Patient Information

Patient

Name: _____

Patient ID: _____

Patient

Group No.: _____

Patient

DOB: _____

Prescribing Physician

Physician

Name: _____

Physician

Phone: _____

Physician

Fax: _____

Physician

Address: _____

City, State,

Zip: _____

Diagnosis: _____

ICD

Code: _____

Please circle the appropriate answer for each applicable question.

1. Did the patient have any IV antiemetic doses at the time of chemotherapy? Y N
 [If the answer to this question is yes, then no further questions required.]
2. Is this drug being used as part of a cancer chemotherapy regimen? Y N
 [If the answer to this question is no, then no further questions required.]
3. Will the oral antiemetic formulation be used as a full therapeutic replacement for intravenous administration of the antiemetic drug within 48 hours of chemotherapy? Y N
 [If the answer to this question is no, then no further questions required.]
4. Will the patient require more than 48 hours (2 calendar days) of antiemetic therapy with this agent? Y N

Comments: _____

I affirm that the information given on this form is true and accurate as of this date.



**Arkansas
BlueCross BlueShield**

An Independent Licensee of the Blue Cross and Blue Shield Association

Prescriber (Or Authorized) Signature and Date