



Prior Authorization Form

**Arkansas Blue Cross and Blue Shield (Medicare)
Medi-Pak Rx (PDP) and Medi-Pak Advantage (PFFS)
Emend 80mg or 125mg PL (Med Determination)**

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 Emend 80mg or 125mg PL (Med Determination).

Drug Name (select from list of drugs shown)

Emend (aprepitant) 125mg Emend (aprepitant) 80mg Emend (aprepitant) 80mg & 125mg Dose Kit

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 |
| 2. Does the patient have the diagnosis of cancer? | Y | N |
| 3. Will this drug be part of a regimen that includes an oral corticosteroid (e.g., dexamethasone) and an oral 5-HT3-receptor antagonist (e.g., Zofran, Kytril, Anzemet)? | Y | N |
| 4. Is the patient receiving one or more of the following chemotherapeutic agents: Carmustine, Cisplatin, Cyclophosphamide, Dacarbazine, Mechlorethamine, Streptozocin, Doxorubicin, Epirubicin, Lomustine? | Y | N |
| 5. Is Emend being prescribed for the prevention of postoperative nausea and vomiting in an adult?
[If the answer to this question is yes, then skip to question 9.] | Y | N |
| 6. Is the patient an adult with a diagnosis of cancer? | Y | N |
| 7. Is Emend being prescribed for the prevention of nausea and vomiting associated with highly or moderately emetogenic chemotherapy? | Y | N |
| 8. Will this drug be part of a regimen that includes a corticosteroid | Y | N |



**Arkansas
BlueCross BlueShield**

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(e.g., dexamethasone) and a 5-HT3-receptor antagonist (e.g., Zofran, Kytril, Anzemet, Aloxi)?

9. Is the patient currently taking cisapride (Propulsid) or pimozone (Orap)? Y N

10. How many courses of chemotherapy is the patient undergoing per month? _____

Comments: _____

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

Prescriber (Or Authorized) Signature and Date