Please complete ALL information below and fax your request to 1-888-671-5285

Emend® (aprepitant) Coverage Determination Request Form (Page 1 of 2)

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Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		Office Contact:
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name: Select one of the following: ❑ Request is for **GENERIC** ❑ Request is for **BRAND** (unable to take the generic)	Strength:	Dosage Form:
❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the Type(s) of Coverage Determination Requested:

❑ **Non-Formulary**- Request is for a drug not on the plan's list of covered drugs OR was previously included on the plan's list is being/was removed from this list during the plan year.

❑ **Prior Authorization**- Request is for a drug that requires prior authorization under the plan.

❑ **Quantity Limit**- Request is for an exception to the plan's quantity limit.

Quantity per MONTH requested? _________

Select the diagnosis below:

❑ Prevention of chemotherapy-induced nausea and vomiting

❑ Prevention of postoperative nausea and vomiting

❑ Other diagnosis: ____ ICD-10 Code(s): ____________________________________

Part B vs D questionnaire:

Is the patient only receiving ORAL chemotherapy? ❑ **Yes** ❑ **No**

Has the drug been ordered by the treating practitioner as part of a cancer chemotherapy regimen? ❑ **Yes** ❑ **No**

Is the drug used as a full therapeutic replacement for an intravenous antiemetic drug that would otherwise have been administered at the time of the chemotherapy treatment? ❑ **Yes** ❑ **No**

Will this oral anti-emetic drug be initiated within two hours of the administration of the chemotherapeutic agent and continued for a period not to exceed 48 hours from that time? ❑ **Yes** ❑ **No**

For brand Emend capsule, select the medication(s) the patient has a history of trial and failure, or intolerance to:

❑ Aprepitant

❑ Emend suspension

❑ Varubi

❑ Other drugs in the same class. Please specify: ____

❑ Other therapeutic equivalent alternatives. Please specify: ____

Quantity limit requests:

Is there a high risk of significant adverse clinical outcome with medication change or dosage change? ❑ **Yes** ❑ **No**

Is the requested quantity and dose within FDA approved maximum dosing limits or supported by peer-reviewed medical literature, accepted standards of medical practice and/or medical compendia? ❑ **Yes** ❑ **No**

If **yes,** please specify:____

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Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

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Please note: This request may be denied unless all required information is received.

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