



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Emend

Phone: 215-991-4300 Fax back to: 866-240-3712

HEALTH PARTNERS manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

<p>Patient Name:</p> <p>Member Number:</p> <p>Date of Birth:</p> <p>Group Number:</p> <p>Address:</p> <p>City, State, Zip:</p> <p>Member Phone:</p>	<p>Prescriber Name:</p> <p>Fax: Phone:</p> <p>Office Contact:</p> <p>NPI: State Lic ID:</p> <p>Address:</p> <p>City, State, Zip:</p>
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Drug Name: Expedited/Urgent

Directions:

Patient belongs to (please check one): HEALTH PARTNERS KIDZPARTNERS

<p>Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign:</p>
<p>Q1. What is the requested duration of treatment? <input type="checkbox"/> One dose <input type="checkbox"/> More than one dose</p>
<p>Q2. Is the age of the patient ≥ 18 years of age? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q3. Is this medication prescribed to prevent postoperative nausea and vomiting (only applicable to aprepitant or EMEND oral capsule)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q4. Is the patient receiving anthracycline and cyclophosphamide (AC)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q5. Please list chemotherapeutic agents.</p>
<p>Q6. Is the patient receiving highly emetogenic cancer chemotherapy including high-dose cisplatin? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q7. Please list chemotherapeutic agents.</p>
<p>Q8. Is this medication prescribed to prevent acute emesis associated with highly-emetogenic chemotherapy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q9. Is this medication prescribed to prevent acute emesis associated AC? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q10. Is this medication prescribed to prevent delayed emesis associated with highly-emetogenic chemotherapy?</p>



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Patient Name:

Prescriber Name:

Yes No

Q11. Is this medication prescribed to prevent delayed emesis associated with AC?

Yes No

Q12. Is the patient receiving a three-drug combination of 5-HT3 Receptor Antagonist such as ondansetron and a corticosteroid such as dexamethasone with Emend?

Yes No

Q13. Is the patient receiving a two-drug combination of dexamethasone and Emend on day 2 and 3 of chemotherapy (for example, cisplatin)?

Yes No

Q14. Is the patient receiving a single agent of EMEND on day 2 and 3 of chemotherapy (for the AC regimen)?

Yes No

Q15. Has the patient tried and failed or intolerant to formulary preferred Selective 5-HT3 Receptor Antagonist such as ondansetron (Zofran®)?

Yes No

Q16. Comments:

Q17. Deliver to:

Physician's Office Home Delivery

Q18. Delivery date needed:

Physician Signature

Date