



**Emend**  
(aprepitant)

**Express Scripts**  
**Prior Authorization**  
**Phone (800) 417-8164**  
**Fax 877-837-5922**

**Please have the information below ready when calling in the authorization.**

Member's Last Name	Member's First Name
SCAN ID number	Date of Birth
Prescriber's Name	Contact Person
Office phone	Office Fax

Medication:	Diagnosis:
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<b>1. Is Emend being given in combination with a 5HT3 antagonist (ondansetron/Zofran, Kytril, or Anzemet) and dexamethasone?</b>
<b>2. Has the patient tried and failed one of the following medications? Please specify.</b>  <input type="checkbox"/> Anzemet <input type="checkbox"/> Kytril <input type="checkbox"/> Ondansetron/Zofran
<b>3. Is patient receiving one or more of the following anti-cancer agents: BiCNU, Gliadel, Cisplatin, Cyclophosphamide, Dacarbazine, Doxorubicin, Ellence, CeeNU, Mustargen, Zanosar?</b>
<b>4. Is Emend being given within 48 hours of the administration of IV chemotherapy?</b>
<b>5. Are there any other comments, diagnoses, symptoms, and/or any other information the caller feels is important to this review?</b>

Notice: **Failure to provide all information requested on this form may result in delayed processing or an adverse determination for insufficient information.** Our response time for prescription drug coverage requests is 72 hours. View our formulary and Prior Authorization forms online at <http://www.scanhealthplan.com>.