Oral Anti-Emetics

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

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

This drug may be covered under Medicare Part B or Part D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Medication:	Diagnosis:

1. **Is this medication being used as a full therapeutic replacement for IV anti-emetic drugs within 2 hours prior to administration of the anti-cancer treatment and not exceeding 48 hours after the treatment?**
2. **Will this medication be used after 48 hours of administration of chemotherapy regimen or for any FDA-approved indication?**
3. **Are there any other comments, diagnoses, symptoms, relevant lab values, and/or additional pertinent information that you feel is important to this review?**

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.