



# Anti-Emetics (injections)

**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:

Medication:	Diagnosis:
-------------	------------

**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.**

1. Is this medication a self-administered drug injected after the administration of the anti-cancer drug or for the treatment of other FDA-approved indications not related to chemotherapy?
2. Is this medication supplied and administered by a physician's office?
3. Are there any other comments, diagnoses, symptoms, relevant lab values, and/or additional pertinent information that you feel is important to this review?

Physician's Signature: _____ NPI/DEA #: _____ Date: _____
---

<u>For Internal Use Only</u> <input type="checkbox"/> Approved <input type="checkbox"/> Denied      Reviewer's Initials _____      Decision Date _____ Comments _____
---

Notice: **Failure to complete this form in its entirety 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>.