



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:

Medication:	Diagnosis:
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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.

<p>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? If no, continue to #2.</p>
<p>2. Will this medication be used after 48 hours of administration of chemotherapy regimen or for any FDA-approved indication?</p>
<p>3. Are there any other comments, diagnoses, symptoms, relevant lab values, and/or additional pertinent information that you feel is important to this review?</p>

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>.