



**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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<p>1. Is Emend being used as 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 #4.</p>
<p>2. Is Emend being given in combination with a 5HT3 antagonist (ondansetron/Zofran, granisetron/Kytril, or Anzemet) and dexamethasone?</p>
<p>3. Is patient receiving one or more of the following anti-cancer agents: BiCNU, Gliadel, Cisplatin, Cyclophosphamide, Dacarbazine, Doxorubicin, Ellence, CeeNU, Mustargen, Zanosar?</p>
<p>4. Is Emend being given after 48 hours of administration of chemotherapy regimen and/or for any FDA-approved indication, not otherwise excluded from Part D?</p>
<p>5. Has the patient tried one of the following formulary 5-HT3 antagonists?</p> <ul style="list-style-type: none"> a. Ondansetron b. Granisetron c. Granisol
<p>6. Are there any other comments, diagnoses, symptoms, and/or any other information the caller feels is important to this review?</p>