



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
VH ID number	Date of Birth
Prescriber's Name	Contact Person
Office phone	Office Fax
Medication:	Diagnosis:

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

