



**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: _____
------------------------------	------------------	-------------

For Internal Use Only <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>.