



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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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?
2. Is Emend being given in combination with a 5HT3 antagonist (ondansetron/Zofran, granisetron/Kytril, or Anzemet) and dexamethasone?
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 after 48 hours of administration of chemotherapy regimen and/or for any FDA-approved indication, not otherwise excluded from Part D?
5. Has the patient tried one of the following formulary 5-HT3 antagonists? a. Ondansetron b. Granisetron
6. 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>.