

Complete Patient and Physician information (PLEASE PRINT)

STEP
1

Member Name:	Physician Name:
Address:	Address:
Member ID:	Phone #:
Member DOB:	Fax #:
	Tax ID or NPI Number:

If Applicable: Pharmacy Name: _____
 Pharmacy Phone: _____

Complete the Clinical Assessment:

STEP
2

Physician Specialty	<input type="checkbox"/> Oncologist	<input type="checkbox"/> Other (please state): _____
Clinical Documentation	<input type="checkbox"/> Emend is being used with a moderate to highly emetogenic chemotherapy regimen With what regimen? _____	<input type="checkbox"/> Other (please state): _____
	<input type="checkbox"/> Emend is being used in combination with a corticosteroid and 5-HT ₃ antagonist Please state which drugs: _____	
Emend IV (fosaprepitant) will only be authorized for one dose and only on day 1 of chemotherapy. Oral Emend should be used on days 2 – 3.		
Supporting Documentation	Diagnosis: ICD-9 Code #/ Description / J Code (required): _____	
	Please attach a copy of the prescription or provide ALL of the information below: Emend® (aprepitant)	
	Strength _____ Sig _____ Qty _____ Refills _____	
Please attach all relevant medical records and test results. Incomplete forms will not be processed.		

STEP
3

I certify that the above is correct and accurate to the best of my knowledge (please sign and date).

Prescriber Signature _____ Date _____

STEP
4

**Fax completed form to the Rocky Mountain Health Plans Pharmacy Help Desk:
 970-248-5034**

Name of Person filling out form: _____

Pharmacy Technician initials _____ Date Initiated _____

Confidentiality Notice:

This facsimile transmission (and/or documents accompanying it) may contain confidential information. This information is intended only for the use of the individual(s) named above. If you have received this transmission in error, or cannot identify the recipient for distribution purposes, please notify us immediately at 970-244-7760. Plans underwritten by Rocky Mountain HMO or Rocky Mountain HealthCare Options 03/10/10