

Emend<sup>®</sup> (aprepitant (oral), fosaprepitant (IV))  
 Prior Authorization Form



**ROCKY MOUNTAIN**  
**HEALTH PLANS<sup>®</sup>**

We understand Colorado. We understand you.

**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"/> Physician supporting post-operative nausea and vomiting <input type="checkbox"/> Other (please state): _____
	Clinical Documentation	<input type="checkbox"/> Prevention of post-operative nausea and vomiting <input type="checkbox"/> Other (please state): _____ <input type="checkbox"/> Emend is being used with a moderate to highly emetogenic chemotherapy regimen (please state regimen): _____ <input type="checkbox"/> Emend is being used in combination with another antiemetic (e.g. 5-HT <sub>3</sub> antagonist) for chemotherapy related nausea and vomiting: Please state which drugs: _____
	<p><b>For cancer patients, 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.</b></p> <p><b>For patients undergoing surgery, Emend will only be authorized for one dose (and only in the oral dosage form).</b></p>	
	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 <sup>®</sup> (aprepitant or fosaprepitant) Strength _____ Sig _____ Qty _____ Refills _____ Please attach all relevant medical records and test results. <p style="text-align: center;"><b>Incomplete forms will not be processed.</b></p>

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

STEP 3  
 \_\_\_\_\_  
 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 01/14/11