

## **Emend (aprepitant) Prior Authorization Request Form**



Caterpillar Prescription Drug Benefit Phone: 877-228-7909 Fax: 800-424-7640

**Instructions:** Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

			URGEN	
MEMBER INFORMATION				
LAST NAME:		FIRST NAME:		
PHONE NUMBER:		DATE OF BIRTH:	DATE OF BIRTH:	
STREET ADDRESS:				
CITY:		STATE: ZIP CO	DDE:	
PATIENT INSURANCE ID	NUMBER:			
MALE FEMALE	HEIGHT (IN/CM): W	EIGHT (LB/KG): ALLE	ERGIES:	
		DISCLOSURE AUTHORIZATION FORM WITH THI OMMON/DOC/EN-US/PHI_DISCLOSURE_AUTH		
		BLE):		
PRESCRIBER INFORMATI	ON			
LAST NAME:		FIRST NAME:	FIRST NAME:	
PRESCRIBER SPECIALTY:		EMAIL ADDRESS:	EMAIL ADDRESS:	
NPI NUMBER:		DEA NUMBER:		
PHONE NUMBER:		FAX NUMBER:		
STREET ADDRESS:				
CITY:		STATE: ZIP CO	DDE:	
REQUESTOR (if different than prescriber):		OFFICE CONTACT PERSO	OFFICE CONTACT PERSON:	
		1		
MEDICATION OR MEDIC	AL DISPENSING INFORMATIO	N		
MEDICATION NAME:				
DOSE/STRENGTH:	FREQUENCY:	LENGTH OF THERAPY/REFILLS:	QUANTITY:	
■ NEW THERAPY ■ RENEWAL DURATION OF THERAPY (SPECIFIC DATES):		IF RENEWAL: DATE THER	IF RENEWAL: DATE THERAPY INITIATED:	
Continued on next page.				

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MEMBER'S LAST NAME: MEMBER'S FIRST NAME:		NAME:		
1. HAS THE PATIENT TRIED ANY OTHE	R MEDICATIONS FOR THIS CONDITION?	YES (if yes, complete below) NO		
MEDICATION/THERAPY (SPECIFY	<b>DURATION OF THERAPY</b> (SPECIFY	RESPONSE/REASON FOR		
DRUG NAME AND DOSAGE):	DATES):	FAILURE/ALLERGY:		
2. LIST DIAGNOSES:		ICD-10:		
El Elot Dinariosco.		105 101		
<b>3. REQUIRED CLINICAL INFORMATION</b> PRIOR AUTHORIZATION.	: PLEASE PROVIDE ALL RELEVANT CLINIC	CAL INFORMATION TO SUPPORT A		
Clinical information:				
Is the patient scheduled to receive mo	derately or highly emetogenic chemot	herapy? □ Yes □ No		
Will Emend be used with a regimen that includes a 5HT3 antagonist (e.g., Zofran, Kytril, or				
Anzemet)? □ Yes □ No				
Will Emend be used with a regimen th	at includes a corticosteroid (e.g., dexa	methasone) and a 5HT3		
antagonist (e.g., Zofran, Kytril, or Anzemet)?   Yes   No				
	•			
For Emend 80mg requests, also answer the following:				
Will Emend 125 mg be given in the medical facility? ☐ Yes ☐ No				
Are there any other comments, diagn	osas symptoms madications triad or f	ailed and/or any other information the		
Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?				
physician reels is important to this ree				
_ · · · · ·	e covered on all plans. This request may	be denied unless all required		
information is received.				
	n provided is true and accurate to the be	, -		
	p or its designees may perform a routing			
information necessary to verify the acc	curacy of the information reported on th	iis iorm.		
Prescriber Signature or Electronic I.D.	Verification:	Date:		
CONFIDENTIALITY NOTICE: The documents acc	ompanying this transmission contain confidentia	I health information that is legally privileged. If		
		ution, or action taken in reliance on the contents		
	have received this information in error, please need documents.	otity the sender immediately (via return FAX)		
and arrange for the return or destruction of the	ese documents.			

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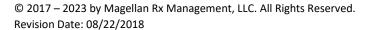


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## **FAX THIS FORM TO: 800-424-7640**

MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program
Attn: CP - 4201
P.O. Box 64811

St. Paul, MN 55164-0811



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