

EMEND 80MG OR 125MG

PHYSICIAN PRIOR AUTHORIZATION REQUEST FORM BlueCross[®] BlueShield[®] of South Carolina

Patient Information	
Name:	Insurance ID #:
Group #:	Birthdate:

Provider Information	
Physician's Name:	Physician DEA #:
Phone:	Fax:
Office Address:	
Diagnosis:	ICD-9 Code:

When this form is complete, please fax to Caremark at 888-836-0730.

This fax machine is in a HIPAA-compliant, secure location. On behalf of BlueCross BlueShield of South Carolina, Caremark assists in the administration of prescription drug programs. Caremark is an independent company that provides pharmacy benefits management.

Call Caremark at 1-800-294-5979 with any questions concerning prior authorization procedures.

- Does the patient have a diagnosis of cancer? Y N
- Will this drug be part of a regimen that includes an oral corticosteroid (e.g., dexamethasone) and an oral 5-HT3-receptor antagonist (e.g., Zofran, Kytril, Anzemet)? Y N
- Is the patient receiving one or more of the following chemotherapeutic agents: Carmustine, Cisplatin, Cyclophosphamide, Dacarbazine, Mechlorethamine, Streptozocin, Doxorubicin, Epirubicin or Lomustine? Y N
- Is Emend being prescribed for the prevention of postoperative nausea and vomiting in an adult?
[If the answer to this question is yes, then skip to question 8.] Y N
- Is the patient an adult with a diagnosis of cancer? Y N
- Is Emend being prescribed for the prevention of nausea and vomiting associated with highly or moderately emetogenic chemotherapy? Y N

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7. Will this drug be part of a regimen that includes a corticosteroid (e.g., dexamethasone) and a 5-HT3-receptor antagonist (e.g., Zofran, Kytril, Anzemet, Aloxi)? Y N
8. Is the patient currently taking cisapride (Propulsid) or pimozone (Orap)? Y N
9. How many courses of chemotherapy is the patient undergoing per month? Y N

Comments: _____

Information on this form is accurate as of the date below.

Prescriber's Signature: 	Date:
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