

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM
EMEND-(aprepitant)

Patient name: _____ Medicaid or SS# _____
Physician Name: _____ Contact person: _____
Phone#: _____ Ext.and options _____ Fax# _____
Pharmacy _____ Pharmacy Phone#: _____

All information to be legible, complete and correct or form will be returned

**FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF
MEDICAL NECESSITY TO (801) 536-0477**

INFORMATION: Used in combination with corticosteroid and other 5HT3 agents, is indicated for the prevention of acute and delayed nausea and vomiting associated with initial and repeat courses of highly emetogenic cancer chemotherapy including high dose Cisplatin

CRITERIA:

- ▶ Patients receiving cancer chemotherapy regimens that are classified as high emetic risk may receive Emend as first-line treatment.
- ▶ Patients on other cancer chemotherapy regimens require a failure on trial of any ONE of the 5HT3 medications (e.g. Zofran, Anzemet, Kytril, or Aloxi)

AUTHORIZATION:

6 months

3 doses per chemotherapy session

RE-AUTHORIZATION:

Telephone request by physician office or pharmacy.