carolina complete health

Pharmacy Request for Prior Approval (Emend/Aprepitant)

Recipient Information

1. Recipient Last Name:_____ 2. First Name:_____
3. Recipient ID #_____ 4. Recipient Date of Birth:_____ 5. Recipient Gender:_____

Payer Information

6. Is this a Medicaid or Health Choice Request? Medicaid: ☐ Health Choice: ☐

Prescriber Information

7. Prescribing Provider #:_____ NPI: ☐ *or* Atypical: ☐
8. Prescriber DEA #: _____
Requester Contact Information
Name:_____ Phone #:_____ Ext:_____

Drug Information

9. Drug Name: _____ 10. Strength:_____ 11. Quantity Per 30 Days: _____
12. Length of Therapy (in days): ☐ up to 30 ☐ 60 ☐ 90 ☐ 120 ☐ 180 ☐ 365 ☐ Other:_____

Clinical Information

1. Is the patient undergoing surgery and requires prevention of postoperative nausea and vomiting? ☐ Yes ☐ No
2. Is the patient receiving highly emetogenic or moderately emetogenic chemotherapy agent? ☐ Yes ☐ No
3. Is the patient receiving concurrent treatment with dexamethasone? ☐ Yes ☐ No
4. Has the patient tried and failed or is the patient intolerant to generic ondansetron, Zofran, Kytril or Anzemet?
☐ Yes ☐ No
5. If request is for a non-preferred drug, has the patient tried and failed on the preferred drug? ☐ Yes ☐ No

Signature of Prescriber:_____ Date:_____

*Prescriber signature mandatory

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to: (877) 386-4695 Pharmacy PA Call Center: (833) 585-4309