

Neighborhood Health Plan of Rhode Island

Prior Authorization Form

Emend® (Aprepitant)

If approval criteria are met Neighborhood Health Plan of Rhode Island will authorize coverage of Emend® (Aprepitant). Failure to fill out this form will result in a rejection of this medication at the pharmacy. Thank you for your assistance. Fax Number **866-423-0945**.

PLEASE COMPLETE THE FOLLOWING SECTIONS:

Patient Name: _____ Member ID# : _____ Date of Request: ____/____/____
 Date of Birth: ____/____/____ Pt. Height in cm: _____ Pt. Weight in kg: _____ Pt. BSA: _____
 Provider Name: _____ Phone: _____ Fax: _____

INDICATIONS FOR USE: (if this is a renewal proceed to question 7)

YES NO

1. Patient is receiving highly emetogenic chemotherapy: <ul style="list-style-type: none"> • patient will qualify if on any agent from level 5, a combination of agents in levels 3 and 4, or a combination of agents in levels 2 and 4. 				<input type="checkbox"/>	<input type="checkbox"/>
Level 2	Level 3	Level 4	Level 5		
Asparaginase Cytarabine (<1g/m ²) Docetaxel Doxorubicin (<20mg/m ²) Etoposide Fluorouracil (<1000mg/m ²) Gemcitabine Methotrexate(>50mg/m ² ; <250mg/m ²) Mitomycin Paclitaxel Teniposide Thiotepa Topotecan	Aldesleukin Cyclophosphamide(i.v. ≤750mg/m ²) Dactinomycin (≤1.5mg/m ²) Doxorubicin (20-60mg/m ²) Epirubicin (≤90mg/m ²) Idarubicin Ifosfamide Methenamine (oral) Methotrexate (250-1000mg/m ²) Mitoxantrone(≤15mg/m ²)	Carboplatin Carmustine(<250mg/m ²) Cisplatin(<50mg/m ²) Cyclophosphamide(>750mg/m ² to ≤1500mg/m ²) Cytarabine (≥1mg/m ²) Dactinomycin (>1.5mg/m ²) Doxorubicin (>60mg/m ²) Irinotecan Melphalan i.v. Methotrexate (≥1000mg/m ²) Mitoxantrone (>15mg/m ²) Procarbazine (oral)	Carmustine (>250mg/m ²) Cisplatin (≥50mg/m ²) cyclophosphamide (>1500mg/m ²) Dacarbazine (≥500mg/m ²) Lomustine (>60mg/m ²) Mechlorethamine Pentostatin Streptozocin		
2. Patient has been treated with a 5HT ₃ antagonist in combination with a corticosteroid for one cycle of chemotherapy				<input type="checkbox"/>	<input type="checkbox"/>
3. Patient experienced: <ul style="list-style-type: none"> • Acute nausea and vomiting • Delayed nausea and vomiting (n/v occurred at > 24 hours post infusion) 				<input type="checkbox"/>	<input type="checkbox"/>
4. Patient is ≥ 18 years of age, pediatric patients will be reviewed on a case by case basis.				<input type="checkbox"/>	<input type="checkbox"/>
5. Prescriber is an Oncologist				<input type="checkbox"/>	<input type="checkbox"/>
6. Prescriber understands Emend® is only to be given in combination with a 5HT ₃ antagonist and a corticosteroid regimen and has ensured patient has these medications available.				<input type="checkbox"/>	<input type="checkbox"/>
7. If this is a renewal: Has the patient experienced a reduction in nausea or emetogenic episodes?				<input type="checkbox"/>	<input type="checkbox"/>

REASONS FOR BENEFIT DENIAL:

YES NO

1. Intended use is not for highly emetogenic chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>
2. Patient is currently taking Orap™ (pimozide) or Propulsid® (cisapride)	<input type="checkbox"/>	<input type="checkbox"/>
3. Patient does not meet above criteria	<input type="checkbox"/>	<input type="checkbox"/>

If patient meets criteria:

- **Initial approval: 6 months** • **Quantity limit: 6 caps/30 days** • **Renewal approval period: 4 months**
- All information provided on this form is accurate as of this date.*

Prescriber's Signature and NPI

Date