BlueCross BlueShield Federal Employee Program

NK1 ANTAGONISTS
PRIOR APPROVAL REQUEST

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Additional information is required to process your claim for prescription drugs. Please complete the cardholder portion, and have the prescribing physician complete the physician portion and submit this completed form.

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Cinvanti (aprepitant) / Emend (aprepitant) / Emend injection (fosaprepitant)

**Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit

NOTE: Form must be completed in its **entirety** for processing

Is this request for brand or generic? ❑Brand ❑Generic

1. Is the prescribing physician a board-certified oncologist? ❑Yes ❑No

2. Complete **Section A** for **Emend 40mg capsules** **OR** **Section B** for **Cinvanti** or **Emend capsule/injection/oral suspension**

SECTION A: Emend 40mg capsules

a. What is the patient's diagnosis?
- ❑ Postoperative nausea and vomiting (PONV)
- ❑ Other diagnosis ***(please specify)***: _____

b. How many Emend 40mg capsules are being requested per 90 days? _____ capsules per 90 days

SECTION B: Cinvanti or Emend capsules/injection/oral suspension

Please select medication and indicate quantity:

❑Cinvanti 130mg injection qty _____ vials per 90 days	**❑Emend 150mg injection qty _____ vials per 90 days**
❑Emend 80mg capsule qty _____ caps per 90 days	**❑Emend 125mg suspension qty _____ kits per 90 days**
❑Emend 125mg capsule qty _____ caps per 90 days	
❑Emend Bi-pack (two 80mg capsules) qty _____ packs per 90 days	
❑Emend Tri-pack (one 125mg and two 80mg capsules) qty _____ packs per 90 days	

a. What is the patient's diagnosis?
- ❑ Prevention of acute or delayed nausea and vomiting
- ❑ Postoperative nausea and vomiting (PONV)
- ❑ Other ***(please specify)***: _____

b. Is the patient undergoing chemotherapy for cancer? ❑Yes ❑No

c. **Requests for Emend oral suspension and/or injection:** What is the patient's weight? _____ kg **OR** _____ lbs

d. Will the requested medication be used in combination with another *antiemetic? ❑Yes ❑No

Antiemetics: Aloxi (palonosetron), Anzemet (dolasetron), Compazine (prochlorperazine), Decadron (dexamethasone), Kytril (granisetron), and Zofran (ondansetron).