Emend (aprepitant)
Prior Authorization Form

South Carolina

BlueCross BlueShield of South Carolina is an independent licensee of the Blue Cross and Blue Shield Association

Medicare Advantage

Patient Information	
Name:	Insurance ID #:
Phone #:	Date of Birth:
Diagnosis:	Diagnosis Code:

Provider Information	
Prescriber's Name:	
Phone:	Fax:
Office Address:	

After you complete this form, please sign and date it. Fax it to Caremark at 1-855-633-7673. Caremark is an independent company that administers the prior authorization program on behalf of the member's health plan. The Caremark fax machine is in a HIPAA-compliant secure location. Call Caremark at 1-855-344-0930 with any questions concerning prior authorization procedures.

Please circle the appropriate answer for each applicable question.

Question		
1. Is Emend being used as part of a cancer chemotherapy regimen? (If yes, skip to question 4.)	Yes	No
2. Does the prescriber (i.e., nephrologist, nurse practitioner, or physician assistant) receive a monthly capitation payment to manage the end stage renal disease (ESRD) patient's care? (If no, then no further questions.)	Yes	No
3. Is the drug prescribed to be used for an ESRD-related condition? (If yes, then no further questions.)	Yes	No
4. Is the patient receiving an oral chemotherapy drug or is the chemotherapy drug being administered intravenously in the home setting? (If yes, then no further questions.)	Yes	No
5. Did the patient have any IV antiemetic doses at the time of chemotherapy? (If yes, then no further questions.)	Yes	No

Question		
6. 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., ondansetron, granisetron, Anzemet)? (If no, then no further questions.)	Yes	No
7. Is the patient receiving one or more of these chemotherapeutic agents? • Carmustine • Cisplatin • Cyclophosphamide • Dacarbazine • Mechlorethamine • Streptozocin • Doxorubicin • Epirubicin • Lomustine	Yes	No

I affirm that the information given on this form is accurate as of this date.

Prescriber (or Authorized) Signature:____ Date:______/______/_20____