BlueCross BlueShield Federal Employee Program

EMEND
PRIOR APPROVAL REQUEST

Send completed form to:
Blue Shield of California
FEP Prior Approval
Fax: 1-855-895-3504

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. All incomplete and illegible forms will be returned to the patient.

CARDHOLDER INFO

Date: ____/ _____/ _____

Cardholder Name: _____/ _____/ _____
First MI Last

Patient Name: _____/ _____/ _____
First MI Last

Patient Address: _____
Street City State Zip

Patient Date of Birth: ____/ _____/ _____ Sex: M ____ F _____ **R** _____
Cardholder Identification Number

PHYSICIAN COMPLETES

Emend (aprepitant)

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

Please select strength and quantity:

- ❑ 40mg capsule ⇨_____ per 90 days
- ❑ 80mg capsule ⇨_____ per 90 days
- ❑ 125mg capsule ⇨_____ per 90 days
- ❑ 150mg injection ⇨_____ vials per 90 days
- ❑ Bi-pack (two 80mg caps) ⇨_____packs per 90 days
- ❑ Tri-pack (one 125mg cap and two 80mg caps) ⇨_____packs per 90 days

1. Is the prescriber a board certified oncologist? ❑Yes ❑No

2. What is the patient's **diagnosis?**

❑Prevention of acute or delayed nausea or vomiting in patients undergoing cancer chemotherapy

a. Will Emend be used in combination with another antiemetic*? ❑Yes ❑No

Antiemetics include, but not limited to: Ondansetron (Zofran), Granisetron (Kytril), Dolasetron (Anzemet), Palonosetron (Aloxi), Dexamethasone (Decadron)

❑Postoperative nausea and vomiting

❑Other diagnosis *(please specify):* _____

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification:** I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer.

_____ (_____) _____ (_____) _____
Physician Name (Print Clearly) Phone Fax

_____ _____ _____ _____
Street Address City State Zip

_____ _____ _____/ _____/ _____
Prescriber's NPI Physician Signature Date