NC Medicaid and NC Health Choice
Pharmacy Prior Approval Request for

Antiemetic Agents: Emend and Aprepitant

Beneficiary Information

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

Prescriber Information

6. Prescribing Provider NPI #: _____
7. Requester Contact Information - Name: _____ Phone #: _____ Ext. ____

Drug Information

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

Clinical Information

1. Is the beneficiary receiving highly emetogenic chemotherapy? ☐ **Yes** ☐ **No**
2. Is the beneficiary receiving a Carboplatin-based chemotherapy regimen? ☐ **Yes** ☐ **No**
3. Is the beneficiary receiving a high-dose chemotherapy and stem cell or bone marrow transplantation? ☐ **Yes** ☐ **No**
4. Is the beneficiary receiving a 4 or 5 day cisplatin-based chemotherapy regimen? ☐ **Yes** ☐ **No**
5. Is the beneficiary receiving concurrent treatment with dexamethasone? ☐ **Yes** ☐ **No**
6. Is the beneficiary receiving concurrent treatment with a 5HT3 receptor antagonist? ☐ **Yes** ☐ **No**
4. Is the beneficiary taking ≤ 125mg daily for 1 day or ≤ 80mg daily for 2 days of Emend/Aprepitant? ☐ **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 CSRA at (855) 710-1969

Pharmacy PA Call Center: (866) 246-8505

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