Blue Cross Blue Shield of Vermont and The Vermont Health Plan
Prior Approval Form
Emend® (Aprepitant)

BCBSVT and TVHP Fax # (888)–255-1006

If approval criteria are met BCBSVT/TVHP will authorize coverage of Emend® (Aprepitant).
Thank you for your assistance.
PLEASE COMPLETE THE FOLLOWING SECTIONS:

Date of Request _______________ Patient Name: ___________________________

Member ID#:____________________ Date of Birth: _____________________________

Provider Name:__________________ Provider Phone: __________________________

Provider Fax: _____________________ PCP Name: ______________________________

INDICATIONS FOR USE: *(if this is a renewal proceed to question 6)*

	YES	NO
1. Patient is receiving highly emetogenic chemotherapy: • 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.	☐	☐

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) Cyclophospamide(>750mg/m^2 to ≤1500mg/m^2) Cytarabine (≥1mg/m^2) Dactinomycin (>1.5mg/m^2) Doxorubicin (>60mg/m^2) Ironotecan 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

	YES	NO
2. Patient has been treated with a 5HT$_3$ antagonist in combination with a corticosteroid for one cycle of chemotherapy	☐	☐
3. Patient experienced: • Acute nausea and vomiting • Delayed nausea and vomiting (n/v occurred at > 24 hours post infusion)	☐ ☐	☐ ☐
4. Patient is ≥ 18 years of age	☐	☐
5. Prescriber is an Oncologist	☐	☐
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.	☐	☐
7. **If this is a renewal:** Has the patient experienced a reduction in nausea or emetogenic episodes?	☐	☐

REASONS FOR BENEFIT DENIAL:	YES	NO
1. Intended use is not for highly emetogenic chemotherapy	☐	☐
2. Patient is currently taking Orap™ (pimozide)	☐	☐

If patient meets criteria:

• **Initial approval: 3 months** • **Quantity limit: 6 caps** • **Renewal approval period: 3 months**

PRESCRIBER SIGNATURE____ DATE_______________

By signing above, the prescriber confirms all information provided is accurate and verifiable via member records.

BlueCross BlueShield of Vermont
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