aetna®

Emend® (fosaprepitant dimeglumine) Injectable Medication Precertification Request

(All fields must be completed and legible for Precertification Review.)

Aetna Precertification Notification
503 Sunport Lane, Orlando, FL 32809
Phone: 1-866-503-0857
FAX: 1-888-267-3277

For Medicare Advantage Part B:
FAX: 1-844-268-7263

Please indicate: ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy: Date of last treatment ____/____/____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:	Last Name:		
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	
DOB:	Allergies:	Email:	

Current Weight: _____ lbs or _____ kgs Height: _____ inches or _____ cms

B. INSURANCE INFORMATION

Member ID #: _____ Does patient have other coverage? ☐ Yes ☐ No
Group #: _____ If yes, provide ID#: _____ Carrier Name: _____
Insured: _____ Insured: _____

Medicare: ☐ Yes ☐ No If yes, provide ID #: _____ **Medicaid**: ☐ Yes ☐ No If yes, provide ID #: _____

C. PRESCRIBER INFORMATION

First Name:	Last Name: *(Check One)*: ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.				
Address:	City:	State:	ZIP:		
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:	Office Contact Name:	Phone:			

Specialty *(Check one)*: ☐ **Oncologist** ☐ **Obstetrician** ☐ **Surgeon** ☐ **Other**: _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____

Dispensing Provider/Pharmacy: *Patient Selected choice*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Mail Order
☐ Other: _____
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for: IV Emend (fosaprepitant dimeglumine) **Dose:** _____ **Frequency:** _____

F. DIAGNOSIS INFORMATION – Please indicate primary ICD Code and specify any other where applicable.

Primary ICD Code: _____ Secondary ICD Code: _____ Other ICD Code: _____

G. CLINICAL INFORMATION – Required clinical information must be completed in its entirety for all precertification requests.

For All Requests (clinical documentation required for all requests):
Please provide current chemotherapy regimen: _____

☐ Yes ☐ No Has the patient had an inadequate response to IV granisetron (Kytril) at the FDA recommended dose to control nausea and vomiting?
☐ Yes ☐ No Has the patient had an inadequate response to IV ondansetron (Zofran) at the FDA recommended dose to control nausea and vomiting?
☐ Yes ☐ No Does the patient have a contraindication to IV granisetron (Kytril)?
☐ Yes ☐ No Does the patient have a contraindication to IV ondansetron (Zofran)?

☐ **For prevention of acute nausea or vomiting associated with initial and repeat courses of chemotherapy**
→ ☐ Yes ☐ No Will the patient be on moderately and highly emetogenic cancer chemotherapy?
☐ Yes ☐ No Will fosaprepitant dimeglumine (Emend) be used with steroids (e.g. dexamethasone) and a 5-HT3 antagonist (e.g. ondansetron (Zofran), granisetron (Kytril))?
→ ☐ Yes ☐ No Will fosaprepitant dimeglumine (Emend) and palonosetron (Aloxi) be used concomitantly?
☐ Yes ☐ No Has the patient failed previous therapy with a steroid plus 5-HT3 antagonist?

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION *(continued)* – Required clinical information must be completed in its entirety for all precertification requests.

☐ **For treatment of chemotherapy-induced nausea or vomiting**
→ ☐ Yes ☐ No Is the patient currently on low or minimally emetogenic cancer chemotherapy?

☐ **For the prevention or treatment of post-operative nausea or vomiting**

☐ **For severe, intractable, persistent nausea or vomiting during pregnancy**
☐ Yes ☐ No Does the patient have clinical signs of dehydration?
→ Please indicate how long the patient's nausea and vomiting has persisted: _____ wks.
→ Please identify the signs exhibited:
☐ Confusion ☐ Constipation ☐ Decreased skin turgor ☐ Decreased urine output
☐ Dizziness/lightheadedness ☐ Dry mucous membranes ☐ Dry skin ☐ Extreme thirst ☐ Few or no tears
☐ Headache ☐ Increased heart rate ☐ Irritability ☐ Low blood pressure ☐ Rapid respiratory rate
☐ Sleepiness or tiredness ☐ Sunken eyes ☐ Other: _____

☐ **For refractory cases of nausea or vomiting for other indications**
→ Please select the indication that is causing the nausea or vomiting:
☐ Bulimia nervosa ☐ Cyclic vomiting syndrome ☐ HIV ☐ None of the above

H. ACKNOWLEDGEMENT

Request Completed By *(Signature Required):* _____ **Date:** ___/___/___

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.