Trillium Health Resources
Pharmacy Prior Approval Request for

Trillium HEALTH RESOURCES
Transforming Lives. Building Community Well-Being.

Antiemetic Agents: Emend/aprepitant (generic)

Member Information

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

Prescriber Information

1. Prescriber Name: _____ 2. NPI #: _____
3. Requestor Name (Nurse/Office Staff): _____
4. Mailing Address: _____ City: _____ State: ____ Zip: _____
5. Phone #: _____ Ext. _____ Fax #: _____

Drug Information

1. Drug Name: _____ 2. Strength: _____ 3. Quantity per 30 Days: _____
4. Length of Therapy (in Days): ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days ☐ 365 Days

Clinical Information

1. Is the member receiving highly emetogenic chemotherapy? ☐ **Yes** ☐ **No**
2. Is the member receiving a Carboplatin-based chemotherapy regimen? ☐ **Yes** ☐ **No**
3. Is the member receiving a high-dose chemotherapy and stem cell or bone marrow transplantation? ☐ **Yes** ☐ **No**
4. Is the member receiving a 4 or 5 day cisplatin-based chemotherapy regimen? ☐ **Yes** ☐ **No**
5. Is the member receiving concurrent treatment with dexamethasone? ☐ **Yes** ☐ **No**
6. Is the member receiving concurrent treatment with a 5HT3 receptor antagonist? ☐ **Yes** ☐ **No**
7. Is the member 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.