MC-Rx
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Emend® (aprepitant)

Ticket #: _____ **Request Date:** _____ **Request Time:** _____

PHYSICIAN CERTIFICATION PRIOR AUTHORIZATION FORM

A request for the patient identified below has been made for the dispensing of **Emend®** aprepitant. Based on recent clinical information, we require more information before this prescription can be paid by the patient's health benefit plan. Please fill out the following information and return to us as indicated below:

A. Member Information		
Patient Name:	Plan Name/Plan ID:	
Patient ID:	Patient Date of Birth:	Patient Contact Phone #:

B. Physician Information		
Physician Name:	Physician Address:	
Physician DEA #:	Physician Phone #:	Physician Fax #:
Drug Name and Strength:	QTY and Days Supply:	NDC # and GCN:

C. Pharmacy Information			
Pharmacy Name:	NABP #:	Pharmacy Phone #:	Pharmacy Fax #:

D. Clinical Information (Please fill out the following information)

1. Diagnosis: _____
2. Chemotherapy Regimen: _____
3. Frequency of Chemotherapy: _____
4. Other medications patient will take with Emend: _____

_____

Dosing Recommendations: Emend is given for 3 days as part of a regimen that includes a corticosteroid and a $5HT_3$ antagonist.
Day 1: 125 mg po 1 hr prior to chemotherapy; Days 2 & 3: 80 mg po in the AM.

Authorized Medical Signature:	
Telephone:	**Date:**

When Completed Return To:

MC-Rx Clinical Division, 1267 Professional Parkway, Gainesville, GA 30507
1-866-965-Drug (3784) / Fax # 866-999-7736

**Please note that this form is to be completed by the prescribing physician. This form and its contents are permissible under HIPAA as the protected health information (PHI) contained in this letter is only being used for purposes related to the provision of treatment, payment and healthcare operations (TPO). HIPAA does restrict the communication of PHI with providers for TPO related purposes.