WellCare
Beyond Healthcare. A Better You.

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.