Prescriber Criteria Form

Emend Varubi 2026 PA Fax BD-3 v1 010126.docx
Oral Antiemetic Agents
Emend (aprepitant), Varubi (rolapitant)
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Oral Antiemetic Agents.

Drug Name (select from list of drugs shown):

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Is the requested drug being used as part of a cancer chemotherapy regimen? [If no, then no further questions.]	Yes	No
2	Will the oral antiemetic formulation be used as a full therapeutic replacement for intravenous administration of an antiemetic within 48 hours of chemotherapy? [If no, then no further questions.]	Yes	No
3	Will the requested drug be part of a regimen that includes an oral corticosteroid (e.g., dexamethasone) and an oral 5-HT3-receptor antagonist (e.g., ondansetron, granisetron, Anzemet)? [If no, then no further questions.]	Yes	No
4	Is the patient receiving one or more of the following chemotherapeutic agents: Alemtuzumab, Azacitidine, Bendamustine, Carboplatin, Carmustine, Cisplatin, Clofarabine, Cyclophosphamide, Cytarabine, Dacarbazine, Daunorubicin, Doxorubicin, Epirubicin, Idarubicin, Ifosfamide, Irinotecan, Lomustine, Oxaliplatin, Streptozocin?	Yes	No

Comments:	

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.
Prescriber (or Authorized) Signature: _____ Date:_____