Prescriber Criteria Form

Antiemetics 2025 PA Fax BD-16 v1 010125.docx
Oral Antiemetic Agents (Except Emend, Varubi, And Akynzeo)
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 (Except Emend, Varubi, And Akynzeo).

Drug Name:

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 oral antiemetic agent 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 an intravenous antiemetic administration within 48 hours of chemotherapy or within 24 hours of chemotherapy if dolasetron or granisetron? [If no, then no further questions.]	Yes	No
3	Will the patient require one of the following: A) more than 24 hours of oral antiemetic therapy of dolasetron or granisetron, B) more than 48 hours of therapy of another requested oral antiemetic drug (excluding dolasetron or granisetron)?	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:**____________________