



Antiemetic Injectable Medication Precertification Request

Aetna Precertification Notification
503 Sunport Lane, Orlando, FL 32809
Phone: 1-866-503-0857
FAX: 1-888-267-3277

Please indicate: Start of treatment Continuation of therapy, date of last treatment _____ **Today's date:** _____

Date needed: _____

Ship to: Doctor's office Patient Other: _____ Phone: _____

Dispensing Provider: Aetna Specialty Pharmacy® or Other: _____
Phone: _____ Fax: _____ TIN: _____ PIN: _____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:		Last Name:	
Address:		City:	State: ZIP:
Home Phone:	Work Phone:	Cell Phone:	
DOB:	Allergies:	Email:	
Patient Current Weight: _____ lbs or _____ kgs		Patient Height: _____ inches or _____ cms	

B. INSURANCE INFORMATION

Aetna Member ID #: _____	Does patient have other coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No
Group #: _____	If yes, provide ID#: _____ Carrier Name: _____
Insured: _____	Insured: _____
Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____	Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____

C. PRESCRIBER INFORMATION

First Name:		Last Name:		(Circle one): M.D. D.O. N.P.	
Address:		City:	State:	ZIP:	
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:		Office Contact Name:		Phone:	

Specialty (Check one): Oncologist Radiation Oncologist Obstetrician Surgeon Other: _____

D. DIAGNOSIS INFORMATION

Primary ICD-9: _____
Secondary ICD-9: _____ Other ICD-9 Code: _____

E. CLINICAL INFORMATION

Request for: IV Aloxi IV Anzemet IV Emend

Yes No Is the patient being treated for chemotherapy induced nausea and vomiting (CINV)?
If yes:
 Yes No Is the patient currently on a chemotherapy regimen that is either highly emetogenic or moderately emetogenic?
Please provide current chemotherapy regimen. _____

Yes No Is the patient being treated for prevention of radiation induced nausea and/or vomiting secondary to total body irradiation?
 Yes No Is the antiemetic being prescribed for the prevention or treatment of post operative nausea or vomiting (PONV)?
 Yes No Is the patient being treated for severe, intractable, persistent nausea or vomiting during pregnancy when clinical signs of dehydration are present or nausea and vomiting have persisted for more than three weeks?
 Yes No Is the patient being treated for refractory cases of nausea or vomiting associated with bulimia nervosa, cyclic vomiting syndrome or HIV?
 Yes No Has the patient failed a trial of IV form of either granisetron (Kytril) or ondansetron (Zofran) at the FDA recommended dose to control nausea and vomiting?
 Yes No Does the patient have a contraindication to granisetron (Kytril) or ondansetron (Zofran)?

F. PRESCRIPTION INFORMATION – To be completed only if Aetna Specialty Pharmacy is Dispensing Provider

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
<input type="checkbox"/> Aloxi IV® CPB # 0724		Infuse _____ mg IV		
<input type="checkbox"/> Anzemet IV® CPB # 0724		Infuse _____ mg IV		
<input type="checkbox"/> Emend IV® CPB # 0724		Infuse _____ mg IV		

*If Aetna Specialty Pharmacy is the dispensing pharmacy, patient benefits will be verified before product is shipped.
*If the prescriber is providing the drug, the provider must verify benefits.

Prescriber's Signature: _____ Date: ____ / ____ / ____

(Required by law if Aetna Specialty Pharmacy is the dispensing pharmacy.)

Interchange is mandated unless practitioner writes the words "BRAND MEDICALLY NECESSARY" in this space: _____