



# NC DMA Pharmacy Request for Prior Approval - Emend

**Recipient Information**

DMA-3101 (V.01)

1. Recipient Last Name: \_\_\_\_\_ 2. First Name: \_\_\_\_\_  
 3. Recipient ID #: \_\_\_\_\_ 4. Recipient Date of Birth: \_\_\_\_\_ 5. Recipient Gender: \_\_\_\_\_

**Payer Information**

6. Is this a Medicaid or Health Choice Request? Medicaid:  Health Choice:

**Prescriber Information**

7. Prescribing Provider #: \_\_\_\_\_ NPI:  or Atypical:

8. Prescriber DEA #: \_\_\_\_\_

**Requester Contact Information**

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Ext: \_\_\_\_\_

**Drug Information**

9. Drug Name: **Emend** 10. Strength: \_\_\_\_\_ 11. Quantity Per 30 Days: \_\_\_\_\_  
 12. Length of Therapy (in days):  up to 30  60  90  120  180  365  Other: \_\_\_\_\_

**Clinical Information**

1. Is the patient undergoing surgery and requires prevention of postoperative nausea and vomiting?  Yes  No
2. Is the patient receiving highly emetogenic or moderately emetogenic chemotherapy agent?  Yes  No
3. Is the patient receiving concurrent treatment with dexamethasone?  Yes  No
4. has the patient tried and failed or is the patient intolerant to generic ondansetron, Zofran, Kytril or Anzemet?  
 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.

Fax this form to CSC at: (855) 710-1969

Pharmacy PA Call Center: (866) 246-8505