



Date \_\_\_\_\_

Client \_\_\_\_\_

### PRIOR AUTH QUESTIONNAIRE- EMEND®

M.D. Last Name: _____	M.D. First Name: _____
Physician Phone: _____	Physician Fax: _____
Patient: _____	ID# _____ DOB _____

**FAILURE TO COMPLETE THE FORM MAY RESULT IN AN AUTOMATIC DENIAL \*\***

- |   |             |                |     |    |
|---|-------------|----------------|-----|----|
| 1. Medication requested (CIRCLE ONE)  | EMEND 80 MG | EMEND TRI-PACK |     |    |
| a. For EMEND 80MG: Will patient be receiving starting dose in medical facility?   |             |                | YES | NO |
| 2. Is Emend being prescribed for the prevention of acute and/or delayed nausea and vomiting associated with moderately or highly ematogenic chemotherapy? |             |                | YES | NO |
| 3. Will this drug be part of a regimen that includes a corticosteroid (e.g., dexamethasone) and a 5-HT3 antagonist (e.g., Zofran, Kytril, Anzemet)?       |             |                | YES | NO |
| 4. Is the physician aware of potentially serious drug-drug interactions associated with this drug? (e.g. warfarin, cisapride, pimozide)                   |             |                | YES | NO |
| 5. How often are the courses of chemotherapy scheduled?   | _____       |                |     |    |
| 6. Physician Signature or name of person providing answers  | _____       |                |     |    |

Physician Comments \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Send or Fax completed form to:  
**877-329-7279**

RESTAT  
11900 W. Lake Park Dr.  
Milwaukee, WI 53224

[www.restat.com](http://www.restat.com)

QUESTIONS PLEASE CALL:  
**877-526-9906**