



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

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QUESTIONS PLEASE CALL:
877-526-9906