



**Outpatient Chemotherapy
Aloxi Request Form
Fax to 833-581-1861
(Medical Benefit Only)**

Member Name: _____

Member Date of Birth: _____

Member UMI: _____

Requesting Physician's Name: _____ NPI Number: _____

Requesting Physician's Address: _____

Office Contact: _____ Phone #: _____ Fax #: _____

Facility: _____ Facility NPI Number: _____

Facility's Address: _____

Date of Service: _____

J Code(s): _____

Diagnosis Code(s): _____

Please answer all of the following clinical questions:

What is the member's chemotherapy regimen? _____

Has the member tried and failed BOTH Kytril (Granisetron) and Zofran (Ondansetron)? _____

Does the member have contraindications to Kytril (Granisetron) or Zofran (Ondansetron)? If so, please list the reason. _____

Is the member to receive Aloxi for the prevention of post-operative nausea and vomiting for up to 24 hours following surgery? _____

Any additional clinical information: _____

****Please verify member's eligibility and benefits through the health plan****

Fax this completed form to Highmark at 1-833-581-1861