HIGHMARK WESTERN NEW YORK

Outpatient Chemotherapy Aloxi Request Form Fax to 833-619-5745

(Medical Benefit Only)

Member Name: _____

Member Date of Birth: _____

Member UMI: _____ ☐ Medicare ☐ Commercial

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 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: _____

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

Please attach all pertinent clinical information

Attached: ☐ **YES** ☐ **NO**

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

Please fax this completed form to Highmark at 1-833-619-5745