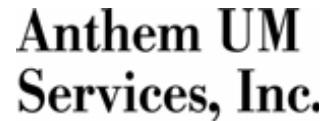


**REVIEW REQUEST FOR
Aloxi (palonosetron) - Antiemetic**



Provider Data Collection Tool Based on CG-DRUG01

Policy Last Review Date: 11/19/2009	Policy Effective Date: 01/13/2010	Provider Tool Effective Date: XX/XX/XX
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Request Date: / /		
<input type="checkbox"/> Initial Authorization Request		<input type="checkbox"/> Subsequent Request
<input type="checkbox"/> Buy and bill		
<input type="checkbox"/> Medication(s) is to be dispensed, delivered, and managed by Precision Rx Specialty Solutions (800-824-2642) FAX		
Ship Medication to: <input type="checkbox"/> MD Office <input type="checkbox"/> Member's Home <input type="checkbox"/> Other: (please specify): _____		
Member Name:		Date of Birth: / /
Insurance Identification Number:		Member Phone Number:
Primary Diagnosis:	ICD-9 Code(s) (if known):	Member's Weight _____ <input type="checkbox"/> (lbs) <input type="checkbox"/> (kg)
Ordering Provider Name & Specialty:		Provider ID Number (if known):
Office Address:		
Contact Name and Office Phone Number:		Office Fax Number:
Servicing Provider Name & Specialty (If different than Ordering Provider):		Provider ID Number (if known):
Office Address:		
Contact Name and Office Phone Number:		Office Fax Number:
Place of Service: <input type="checkbox"/> Home <input type="checkbox"/> Office <input type="checkbox"/> Dialysis Center <input type="checkbox"/> Outpatient Hospital <input type="checkbox"/> Ambulatory Infusion <input type="checkbox"/> Ambulatory Infusion Center <input type="checkbox"/> Other: _____		
Drug Name/HCPS Code (if known) Aloxi <input type="checkbox"/> J2469 Other: _____		Dose to be administered: _____ (mg)
When did the member first start this drug? / /		Frequency (Days, Wks, Months) _____
Duration: _____ (Weeks)		Start Date For This Request: / /

Please check all that apply to the member:

Complete this section before proceeding to the following disease specific sections:

Please check if the member has been treated with any chemotherapy medications in the past (If checked, provide the chemotherapy medications that the member has received): _____

(1) Chemotherapy Induced Nausea and Vomiting (check a response to each that applies)

- Member is receiving moderately to highly emetogenic chemotherapy
- Please list chemotherapy agent (s) _____
- This will be used as prophylaxis for the prevention of acute chemotherapy induced nausea and vomiting
- This will be used as prophylaxis for the prevention of delayed chemotherapy induced nausea and vomiting

Anthem UM Services, Inc., a separate company, is the licensed utilization review agent that performs utilization management services on behalf of your health benefit plan or the administrator of your health benefit plan.

Other: _____

(2) Postoperative Nausea and Vomiting

This will be used as prophylaxis

This will be administered within 24 hours of surgery

Other: _____

(3) Other Use(s) (Please submit all supporting documents including labs, progress notes, imaging, etc., for review.)

This request is being submitted:

Pre-Claim

Post-Claim. If checked, please attach the claim or indicate the claim number _____

I attest the information provided is true and accurate to the best of my knowledge. I understand that Anthem may perform a routine audit and request the medical documentation to verify the accuracy of the information reported on this form.

Name & Title of Provider or Provider Representative Completing Form

/ /

Date

& attestation (Please Print)*

***The attestation fields must be completed by a provider or provider representative in order for the tool to be accepted**
