



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

Member Name: \_\_\_\_\_

Member Date of Birth: \_\_\_\_\_

Member ID (UMI): \_\_\_\_\_  Medicare  Commercial

**ORDERING/ATTENDING PROVIDER**

Name: \_\_\_\_\_ NPI: \_\_\_\_\_

Address: \_\_\_\_\_

Office Contact: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

**SERVICING FACILITY/VENDOR**

Name: \_\_\_\_\_ NPI: \_\_\_\_\_

Address: \_\_\_\_\_

Requested Start Date of Service: \_\_\_\_\_

HCPCS J Code: \_\_\_\_\_ ICD10 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\*\***

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