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****