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

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