



**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\*\***