Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

Horizon NJ Health
Rolapitant (Varubi) – Medical Necessity Request
****Complete page 1 for Initial Requests Only****

1. Is Varubi being used for the prevention of delayed or acute nausea and vomiting associated with initial and repeat courses of emetogenic cancer chemotherapy? **Yes or No**
   a. If No, what is Varubi being used for? _____

2. Will Varubi be given in combination with other therapy? **Yes or No**
   a. If Yes, please list what medication(s) Varubi will be given with?
   _____

3. Will the member be taking any CYP2D6 substrates with a narrow therapeutic index [e.g. thioridazine and pimozide]) with Varubi? **Yes or No**

4. Has the member tried a generic oral antagonist of human substance P/neurokinin 1 (NK1) receptors (e.g. aprepitant or fosaprepitant)?
   □ **Yes** - Why was it discontinued? _____
   □ **No –** Can the member try a drug such as aprepitant or fosaprepitant instead?
   □ **Yes:** Please call the prescription for the requested drug in to the pharmacy
   □ **No:** Please provide clinical reasoning why aprepitant or fosaprepitant cannot be tried:
   _____
   _____

Physician office's signature*_____ Print Name_____
***Form must be completed and signed by physician or licensed representative from the physician's office**

Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

Horizon NJ Health
Rolapitant (Varubi) – Medical Necessity Request
****Complete page 2 only for Subsequent/Renewal requests****

1. Is the member responding positively to therapy? **Yes or No**
2. Does the member continue to receive moderately to highly emetogenic cancer chemotherapy? **Yes or No**
3. Will the member be using Varubi in combination with a corticosteroid (e.g., dexamethasone)? **Yes or No**
4. Will the member be using Varubi in combination with a 5-HT3 receptor antagonist (e.g. ondansetron, granisetron, dolasetron)? **Yes or No**

Physician office's signature*_____ Print Name_____
***Form must be completed and signed by physician or licensed representative from the physician's office**