

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 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

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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