FUTURE SCRIPTS

Please complete ALL information below and fax your request to 1-888-671-5285

Cesamet®, Marinol® (dronabinol), Syndros® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if **generic substitution** is acceptable ❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the diagnosis below:

❑ Anorexia with weight loss in patients with acquired immune deficiency syndrome (AIDS) [**Marinol (dronabinol) & Syndros only**]
❑ Nausea and vomiting in patients receiving cancer chemotherapy
❑ Other diagnosis: _____ ICD-10 Code(s): _____

Anorexia with weight loss in patients with AIDS:

Is the patient on antiretroviral therapy? ❑ **Yes** ❑ **No**
Is the patient unable to swallow capsules? ❑ **Yes** ❑ **No**

Select the medications the patient has a failure, contraindication, or intolerance to:

❑ Dronabinol capsule
❑ Megace (megestrol)

Nausea and vomiting in patients receiving cancer chemotherapy:

Is the patient unable to swallow capsules? ❑ **Yes** ❑ **No**

Select the medications the patient has a failure, contraindication, or intolerance to:

❑ Ativan (lorazepam) ❑ Dronabinol capsule ❑ Reglan (metoclopramide)
❑ Compazine (prochlorperazine) ❑ Haldol (haloperidol) ❑ Zyprexa (olanzapine)
❑ Decadron (dexamethasone) ❑ Phenergan (promethazine)
❑ A 5-HT3 receptor antagonist [e.g., Anzemet (dolasetron), Kytril (granisetron), Zofran (ondansetron)]

Quantity limit request:

What is the quantity being requested per DAY: _____
Is the patient receiving moderately to highly emetogenic chemotherapy? ❑ **Yes** ❑ **No**
Has the patient had at least a partial response to therapy at a dose within the quantity limit? ❑ **Yes** ❑ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.