1230 US Highway 11
Gouverneur, NY 13642
Phone: 1-877-635-9545
Prior Authorization Fax: 1-844-712-8129

Cesamet® & Marinol® (dronabinol) Prior Authorization Request Form (Page 1 of 2)

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 requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Anorexia with weight loss in patients with acquired immune deficiency syndrome (AIDS) [**Marinol (dronabinol)** 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**

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

❑ Dronabinol
❑ Megace (megestrol)

Nausea and vomiting in patients receiving cancer chemotherapy:

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

❑ Ativan (lorazepam) ❑ Dronabinol ❑ 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**

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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.

Please fax this form to 1-844-712-8129 to initiate a prior authorization review for the member and medication above.

Please note: plan benefits may limit or exclude coverage of specific medications including those requested on this form.

I certify, to the best of my knowledge, the statements and information provided on this form are factual and correct.

Provider/Representative (and Title): _____ **Date:** _____

PROACT INTERNAL USE ONLY:					
Clinical Review Decision					
	Approved, through				
	Denied (documentation attached, if necessary)				
Tracking:					
1st Attempt		2nd Attempt		Letter Mailed:	