

Pharmacy Prior Authorization Form

For Prior Authorization please fax to: (877)974-4411 toll free, or (616)942-8206

This form applies to: Commercial Plan Medicaid Plan Medicare Plan

Marinol (dronabinol)

Urgent Non-urgent

Member Name:	Member #:
DOB:	Gender:
Provider Name:	Provider Phone:
Provider Office Address:	
Provider Office Contact Name:	Provider Fax:
Provider Signature:	Provider NPI:
Date:	Member's PCP:

Product:

- Marinol (dronabinol) 2.5 mg
- Marinol (dronabinol) 5 mg
- Marinol (dronabinol) 10 mg

Dose: _____ Start date: _____

Priority Health Precertification Requirements:

Authorization of Marinol requires:

- Diagnosis of nausea and vomiting associated with cancer chemotherapy in patients who have failed to respond adequately to conventional antiemetic treatments
- If Marinol is used within 48 hours of chemotherapy, it is considered a Medicare Part B benefit
- If Marinol is not used within 48 hours of chemotherapy, it is considered a Medicare Part D benefit

Please Complete the Following Information:

Diagnosis:

- Nausea and vomiting associated with cancer chemotherapy
Medication will be used within 48 hours of chemotherapy
 - Yes
 - No

AIDS Wasting

Other: _____

Rationale for use: _____

NOTE: Prior authorization is not approved for use in patients with anorexia associated with weight loss.

*** All fields must be complete and legible for Prior Authorization Review***

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YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX