

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

Dronabinol, THC

URGENT (life threatening)

Non-Urgent (standard review)

A claim involving "urgent care" applies when the standard review time will seriously jeopardize the life or health of the member, or subject the member to severe pain that cannot be managed without the care or treatment requested in the subject of this request. **Priority Health averages between 1 and 3 business days for our standard review response time.**

Member Information

Member Name:	Member No.:
DOB: Gender:	
Member's PCP:	

Provider Information

Provider Name:	
Office Contact Name:	Provider Phone:
Provider NPI:	Provider Fax:
Provider Address:	

Provider Signature _____

Date _____

PRODUCT INFORMATION

dronabinol 2.5mg 5mg 10mg **Dosing Frequency:** _____

PRECERTIFICATION REQUIREMENTS

MEDICARE NOTE: Drug must be prescribed for a medically accepted indication approved by CMS.

What is the patient's diagnosis?

- AIDS – Loss of appetite
- Chemotherapy-induced nausea and vomiting; Prophylaxis
Will dronabinol be used within 48 hours of chemotherapy? Yes (Part B) No (Part D)
- Postoperative nausea and vomiting; Treatment and/or Prophylaxis
- Other: _____
 Rationale for use: _____

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

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YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX