PriorityHealth

Pharmacy Prior Authorization Form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☐ **Commercial (Traditional)** ☐ **Commercial (Individual/Optimized)** ☒ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Dronabinol

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product Information

☐ New Request ☐ Continuation Request

Drug product:

☐ Dronabinol 2.5 mg capsule
☐ Dronabinol 5 mg capsule
☐ Dronabinol 10 mg capsule

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dosing frequency: _____

Precertification Requirements

Before this drug is covered, the patient must meet all of the following requirements:

1. Diagnosis of chemotherapy induced nausea and vomiting and meet the following:
   - Must be receiving chemotherapy; AND
   - Trial and failure, intolerance or contraindication to an emetic regimen consistent with NCCN guidelines including ondansetron, granisetron, dexamethasone, promethazine, or prochlorperazine.

2. Appetite stimulation in AIDS patients and meet the following:
   - Patient must have AIDS with anorexia associated with weight loss; AND
   - Must have trial and failure, intolerance, or contraindication to megestrol.

Note: Authorization for indications, dosing, or a route of administration not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

New request
Priority Health Precertification Documentation

A. What condition is this drug being requested for?

☐ Chemotherapy induced nausea and vomiting
☐ AIDS with anorexia associated with weight loss
☐ *Other – the patient's condition is:* _____

Rationale for use: _____

All fields must be complete and legible for review. Your office will receive a response via fax.

Updated 03/2018
Last reviewed 11/2018

B. Is the patient receiving chemotherapy?

- ☐ Yes
- ☐ No
- ☐ N/A

C. Please list what antiemetic regimen the member has trialed, date and outcome:

- ☐ Ondansetron, date/outcome: _____
- ☐ Granisetron, date/outcome: _____
- ☐ Dexamethasone, date/outcome: _____
- ☐ Promethazine, date/outcome: _____
- ☐ Prochlorperazine, date/outcome:_____
- ☐ Megestrol, date/outcome: _____
- ☐ None of the above, rationale: _____

Additional information

Note: Duration of approval for chemotherapy induced nausea and vomiting will be limited based on the plan of care developed utilizing the chemotherapeutic agents.

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Updated 03/2018
Last reviewed 11/2018