

**FORWARDHEALTH  
PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL)  
FOR ANTIEMETICS, CANNABINOIDS**

**Instructions:** Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Antiemetics, Cannabinoids Completion Instructions, F-00194A. Providers may refer to the Forms page of the ForwardHealth Portal at [www.forwardhealth.wi.gov/WIPortal/Content/provider/forms/index.htm.spage](http://www.forwardhealth.wi.gov/WIPortal/Content/provider/forms/index.htm.spage) for the completion instructions.

Pharmacy providers are required to have a completed Prior Authorization/Preferred Drug List (PA/PDL) for Antiemetics, Cannabinoids form signed by the prescriber before calling the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system or submitting a PA request on the Portal or on paper. Providers may call Provider Services at (800) 947-9627 with questions.

**SECTION I — MEMBER INFORMATION**

1. Name — Member (Last, First, Middle Initial)

2. Member Identification Number

3. Date of Birth — Member

**SECTION II — PRESCRIPTION INFORMATION**

4. Drug Name

5. Drug Strength

6. Date Prescription Written

7. Directions for Use

8. Name — Prescriber

9. National Provider Identifier (NPI) — Prescriber

10. Address — Prescriber (Street, City, State, ZIP+4 Code)

11. Telephone Number — Prescriber

**SECTION III — CLINICAL INFORMATION (For PA requests for dronabinol, providers are required to complete Section III, Section III A or Section III B, and Section VI of this form and submit the request to ForwardHealth on the ForwardHealth Portal or on paper by mail or fax. Prior authorization requests for dronabinol must include clinical justification for prescribing dronabinol instead of Marinol<sup>®</sup>. Additional documentation should be included in Section VI or submitted as an attachment.)**

12. Diagnosis Code and Description

**SECTION III A — CLINICAL INFORMATION FOR MARINOL<sup>®</sup> ONLY**

13. Has the member been diagnosed with a loss of appetite / weight loss caused by Human Immunodeficiency Virus or Acquired Immune Deficiency Syndrome?

Yes  No

**SECTION III B — CLINICAL INFORMATION FOR MARINOL<sup>®</sup> AND CESAMET**

14. Has the member experienced a treatment failure with ondansetron for chemotherapy-related nausea and vomiting?

Yes  No

15. Does the member have a medical condition(s) preventing the use of ondansetron?

Yes  No

If yes, list the medical condition(s) that prevents the use of ondansetron in the space provided.

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**SECTION III B — CLINICAL INFORMATION FOR MARINOL<sup>®</sup> AND CESAMET (Continued)**

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16. Is there a clinically significant drug interaction between another medication the member is taking and ondansetron?  Yes  No

If yes, list the other medication the member is taking and describe the clinically significant drug interaction in the space provided.

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17. Has the member experienced a clinically significant adverse drug reaction while taking ondansetron?  Yes  No

If yes, describe the clinically significant adverse drug reaction in the space provided.

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18. Has the member experienced a treatment failure with Emend<sup>®</sup> for chemotherapy-related nausea and vomiting?  Yes  No

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19. Does the member have a medical condition(s) preventing the use of Emend<sup>®</sup>?  Yes  No

If yes, list the medical condition(s) that prevents the use of Emend<sup>®</sup> in the space provided.

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20. Is there a clinically significant drug interaction between another medication the member is taking and Emend<sup>®</sup>?  Yes  No

If yes, list the other medication the member is taking and describe the clinically significant drug interaction in the space provided.

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21. Has the member experienced a clinically significant adverse drug reaction while taking Emend<sup>®</sup>?  Yes  No

If yes, describe the clinically significant adverse drug reaction in the space provided.

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**SECTION III C — CLINICAL INFORMATION FOR CESAMET ONLY (Complete Section III B and Section III C for requests for Cesamet.)**

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22. Has the member experienced a treatment failure with Marinol<sup>®</sup> for chemotherapy-related nausea and vomiting?  Yes  No

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**SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA**

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23. National Drug Code (11 Digits)	24. Days' Supply Requested (Up to 183 Days)
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25. NPI

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26. Date of Service (MM/DD/CCYY) (For STAT-PA requests, the date of service may be up to 31 days in the future and / or up to 14 days in the past.)

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27. Place of Service

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28. Assigned PA Number

29. Grant Date	30. Expiration Date	31. Number of Days Approved
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**SECTION V — AUTHORIZED SIGNATURE**

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32. SIGNATURE — Prescriber	33. Date Signed
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**SECTION VI — ADDITIONAL INFORMATION**

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34. Include any additional information in the space below. Additional diagnostic and clinical information explaining the need for the product requested may be included here.

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