

**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 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 submitting a PA request on the Portal, by fax, or by mail. 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 and either Section III A or Sections III B and III C of this form.)

12. Diagnosis Code and Description

SECTION III A — CLINICAL INFORMATION FOR MARINOL[®] FOR HIV- AND AIDS-RELATED WEIGHT LOSS OR CACHEXIA

13. Is the member experiencing weight loss or cachexia caused by Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS)? Yes No

14. Current Height — Member (In Inches)

15. Current Weight — Member (In Pounds)

Weight _____ (lbs)

Date Taken ____ / ____ / ____
Month Day Year

16. Body Mass Index (BMI) — Member (lb/in²)

$$\text{BMI} = \frac{703 \times (\text{Weight in Pounds})}{(\text{Height in Inches})^2}$$

17. List the details about the actions used to increase the member's dietary intake.

Continued



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**SECTION III A — CLINICAL INFORMATION FOR MARINOL[®] FOR HIV- AND AIDS-RELATED WEIGHT LOSS OR CACHEXIA
(Continued)**

18. List the details about the member's current dietary plan, including daily caloric intake.

19. Indicate the member's normal baseline weight (in pounds).

20. Is the member currently taking Marinol[®]? Yes No

If yes, list the date Marinol[®] was started. _____

List the daily dose of Marinol[®]. _____

List the member's weight (in pounds) prior to starting Marinol[®] treatment. _____

SECTION III B — CLINICAL INFORMATION FOR MARINOL[®] AND CESAMET FOR CHEMOTHERAPY-RELATED NAUSEA AND VOMITING

21. Is the member experiencing chemotherapy-related nausea and vomiting? Yes No

22. Has the member experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction with ondansetron? Yes No

If yes, list the dates ondansetron was taken. _____

Describe the unsatisfactory therapeutic response or clinically significant adverse drug reaction.

23. Is there a clinically significant drug interaction between another drug(s) the member is taking and ondansetron? Yes No

If yes, list the drug(s) and interaction(s) in the space provided.

24. Does the member have a medical condition(s) that prevents the use of ondansetron? Yes No

If yes, list the medical condition(s) and describe how the condition(s) prevents the member from using ondansetron in the space provided.

SECTION III B — CLINICAL INFORMATION FOR MARINOL® AND CESAMET FOR CHEMOTHERAPY-RELATED NAUSEA AND VOMITING (Continued)

25. Has the member experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction with Emend®? Yes No

If yes, list the dates Emend® was taken. _____

Describe the unsatisfactory therapeutic response or clinically significant adverse drug reaction.

26. Is there a clinically significant drug interaction between another drug(s) the member is taking and Emend®? Yes No

If yes, list the drug(s) and interaction(s) in the space provided.

27. Does the member have a medical condition(s) that prevents the use of Emend®? Yes No

If yes, list the medical condition(s) and describe how the condition(s) prevents the member from using Emend® in the space provided.

SECTION III C — ADDITIONAL CLINICAL INFORMATION FOR DRONABINOL REQUESTS (Prior authorization requests for dronabinol must include clinical justification for prescribing dronabinol instead of Marinol®.)

28. Provide detailed clinical information why the member cannot use Marinol® and why it is medically necessary that the member receive dronabinol instead of Marinol®.

SECTION IV — AUTHORIZED SIGNATURE

29. SIGNATURE — Prescriber

30. Date Signed

SECTION V — ADDITIONAL INFORMATION

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