

**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 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 — Prescriber

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

11. Telephone Number — Prescriber

**SECTION III — CLINICAL INFORMATION**

12. Diagnosis Code and Description

**SECTION III A — CLINICAL INFORMATION FOR DRONABINOL FOR HIV- AND AIDS-RELATED WEIGHT LOSS OR CACHEXIA**

13. Is the member experiencing weight loss or cachexia caused by HIV or 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/in<sup>2</sup>)

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

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

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

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

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

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20. Is the member currently taking dronabinol?  Yes  No

If yes, list the date dronabinol was started. \_\_\_\_\_

List the daily dose of dronabinol. \_\_\_\_\_

List the member's weight (in pounds) prior to starting dronabinol treatment. \_\_\_\_\_

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**SECTION III B — CLINICAL INFORMATION FOR DRONABINOL AND CESAMET FOR CHEMOTHERAPY-RELATED NAUSEA  
AND VOMITING**

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

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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.

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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.

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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.

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

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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.

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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.

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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.

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**SECTION IV — AUTHORIZED SIGNATURE**

28. SIGNATURE — Prescriber

29. Date Signed

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**SECTION V — ADDITIONAL INFORMATION**

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

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