DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-00194 (07/15)

STATE OF WISCONSIN
Wis. Admin. Code § DHS 107.10(2)

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

Continued

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

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

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 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. _____

SECTION III B — CLINICAL INFORMATION FOR DRONABINOL 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.

Continued

SECTION III B — CLINICAL INFORMATION FOR DRONABINOL 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 IV — AUTHORIZED SIGNATURE

28. **SIGNATURE** — Prescriber	29. Date Signed

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.

Reset Form