DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-00194 (07/2020)

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

FORWARDHEALTH

PRIOR AUTHORIZATION DRUG ATTACHMENT FOR ANTIEMETICS, CANNABINOIDS

INSTRUCTIONS: Type or print clearly. Before completing this form, read the Prior Authorization Drug Attachment for Antiemetics, Cannabinoids Instructions, F-00194A. Providers may refer to the Forms page of the ForwardHealth Portal at https://www.forwardhealth.wi.gov/WIPortal/Subsystem/Publications/ForwardHealthCommunications.aspx?panel=Forms for the completion instructions.

Pharmacy providers are required to have a completed Prior Authorization Drug Attachment 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 ID 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. Phone Number – Prescriber

SECTION III – CLINICAL INFORMATION

12. Diagnosis Code and Description

SECTION III A – CLINICAL INFORMATION FOR DRONABINOL FOR ANOREXIA ASSOCIATED WITH WEIGHT LOSS WITH AIDS

Note: A copy of the member's medical records must be submitted with the PA request.

13. Does the member have AIDS?	❑	Yes	❑	No
14. Is the member experiencing anorexia associated with weight loss?	❑	Yes	❑	No

DT-PA086-086

15. Current Height – Member (In Inches):

_____

Current Weight – Member (In Pounds):

_____

Date Current Weight Taken:

_____

Current Body Mass Index – Member (lb/in^2):

_____

16. Baseline Weight – Member (In Pounds):

_____

Date Baseline Weight Taken:

_____

Baseline Body Mass Index – Member (lb/in^2):

_____

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

17. Has the member's daily caloric intake been optimized? ☐ Yes ☐ No

18. Is the member currently taking dronabinol? ☐ Yes ☐ No

If yes, list the date dronabinol was started. _____

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

Note: A copy of the member's medical records must be submitted with the PA request.

19. Is the member currently receiving chemotherapy? ☐ Yes ☐ No

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

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

If yes, list the date(s) ondansetron was taken. _____

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

22. 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).

23. 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.

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

If yes, list the date(s) granisetron was taken. _____

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

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

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

26. Does the member have a medical condition(s) that prevents the use of granisetron? ☐ Yes ☐ No

If yes, list the medical condition(s) and describe how the condition(s) prevents the member from using granisetron.

27. Has the member experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction with at least one of the following chemotherapy-related nausea and vomiting treatments: dexamethasone, haloperidol, lorazepam, metoclopramide, olanzapine, prochlorperazine, or promethazine? ☐ Yes ☐ No

If yes, list the drug name(s) and approximate date(s) taken, and describe the unsatisfactory therapeutic response or clinically significant adverse drug reaction.

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