**DEPARTMENT OF HEALTH SERVICES STATE OF WISCONSIN**

Division of Medicaid Services Wis. Admin. Code § DHS 107.10(2)

F-00194 (07/2021)

**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. Prescribers may refer to the Forms page of the ForwardHealth Portal at [https://www.forwardhealth.wi.gov/WIPortal/Subsystem/Publications/ForwardHealthCommunications.aspx?panel=Forms](https://www.forwardhealth.wi.gov/WIPortal/Subsystem/Publications/ForwardHealthCommunications.aspx?panel=Forms%20) for the completion instructions.

Pharmacy providers are required to have a completed Prior Authorization Drug Attachment for Antiemetics, Cannabinoids form signed and dated by the prescriber before submitting a prior authorization request on the Portal, by fax, or by mail. Prescribers and pharmacy providers may call Provider Services at 800-947-9627 with questions.

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| **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. Address – Prescriber (Street, City, State, Zip+4 Code) | | | | |
| 10. Phone Number – Prescriber | | 11. National Provider Identifier – Prescriber | | |
| **SECTION III – CLINICAL INFORMATION** | | | | |
| 12. Diagnosis Code and Description | | | | |
| **SECTION III A – CLINICAL INFORMATION FOR DRONABINOLFOR 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 | | | | |
| 15. Current Height – Member (In Inches):    Current Weight – Member (In Pounds):    Date Current Weight Taken:    Current Body Mass Index – Member (lb/in2): | 16. Baseline Weight – Member (In Pounds):    Date Baseline Weight Taken:    Baseline Body Mass Index – Member (lb/in2): | | | |
| Body Mass Index = 703 X (Weight in Pounds)  (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 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 dates 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 dates 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 dates 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. | | | |