**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 [ ]  NoIf 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 [ ]  NoIf 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 memberis taking and ondansetron? [ ]  Yes [ ]  NoIf yes, list the drug(s) and interaction(s).      |
| 23. Does the member have a medical condition(s) that prevents the use of ondansetron? [ ]  Yes [ ]  NoIf 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 [ ]  NoIf 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 memberis taking and granisetron? [ ]  Yes [ ]  NoIf yes, list the drug(s) and interaction(s).      |
| 26. Does the member have a medical condition(s) that prevents the use of granisetron? [ ]  Yes [ ]  NoIf 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-relatednausea and vomiting treatments: dexamethasone, haloperidol, lorazepam, metoclopramide, olanzapine, prochlorperazine, or promethazine? [ ]  Yes [ ]  NoIf 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.      |