

Date of Request: \_\_\_\_\_

## Sterling Retiree Rx Prior Authorization Form

### DRONABINOL

**Coverage Criteria / Required Medical Information**

- A.** The diagnosis is documented as anorexia associated with weight loss in a patient with AIDS
- a. **and** the patient has had an involuntary weight loss of > 10% of pre-illness baseline body weight or a body mass index (BMI) < 20kg/m<sup>2</sup> in the absence of a concurrent illness or medical condition other than HIV that may cause weight loss
  - b. **and** the patient has failed to respond to a 30-day drug regimen of megestrol (Megace)
  - c. **and** if the participant has received previous dronabinol therapy, he/she must show a positive response to therapy by maintaining or increasing their initial weight and/or muscle mass before initiating dronabinol therapy.
- B.** The diagnosis is documented as nausea and vomiting associated with cancer chemotherapy in a cancer patient
- a. **and** the participant is receiving a chemotherapy or radiation regimen
  - b. **and** if dronabinol is NOT being used as a full therapeutic replacement for an intravenous anti-emetic drug (e.g., ondansetron)
  - c. **and** if dronabinol is being used as a full therapeutic replacement for an intravenous anti-emetic drug (e.g., ondansetron) **but** dronabinol will NOT be used within 48 hours of cancer therapy
  - d. **and** the patient has had a full trial and failure through at least one cycle of chemotherapy with IV ondanestron **and** at least one of the following oral anti-emetic agents: metoclopramide, promethazine, prochlorperazine, meclizine, trimethobenzamide, oral 5-HT<sub>3</sub> receptor antagonists
  - e. **and** if the participant has received previous dronabinol therapy, he/she must show a positive response by showing a reduced incidence of emesis and/or nausea.

B vs D coverage determination per CMS guidelines

**Coverage Duration:** 6 months

#### Member Information

|   |  |              |  |                     |  |
|---|--|--------------|--|---------------------|--|
| <b>Name</b>                             |  |              |  |                     |  |
| <b>Enrollment/Card-holder ID Number</b> |  |              |  |                     |  |
| <b>Group/Plan</b>                       |  | <b>Male</b>  |  | <b>Female</b>       |  |
| <b>Date of Birth</b>                    |  | <b>Age</b>   |  | <b>Weight in Kg</b> |  |
| <b>Street Address</b>                   |  |              |  |                     |  |
| <b>City</b>                             |  | <b>State</b> |  | <b>Zip</b>          |  |

#### Physicians Information

|                         |  |                     |  |            |  |
|-------------------------|--|---------------------|--|------------|--|
| <b>Name</b>             |  |                     |  |            |  |
| <b>Agent</b>            |  | <b>Contact Name</b> |  |            |  |
| <b>Specialty/Office</b> |  |                     |  |            |  |
| <b>Clinic Name</b>      |  |                     |  |            |  |
| <b>Street Address</b>   |  |                     |  |            |  |
| <b>City</b>             |  | <b>State</b>        |  | <b>Zip</b> |  |
| <b>Phone</b>            |  | <b>Fax</b>          |  |            |  |



**Sterling Retiree Rx Prior Authorization Form**

| Requested Drug                                 |                    |  |     |
|--|--------------------|--|-----|
| DRONABINOL                                     | Reason for Request |  |     |
|  |                    |  |     |
| Condition/Diagnosis Related                    |                    |  |     |
| Clinical Drug/Lab History Pertinent to Request |                    |  |     |
| Labs: Baseline/Ongoing                         | Strength/Dosage    |  |     |
|  |                    |  |     |
| Formulary Alternative(s) Attempted?            | Yes:               |  | No: |
| Please List Alternative Formulary Drugs        |                    |  |     |
|  |                    |  |     |
|  |                    |  |     |
| Comments                                       |                    |  |     |

Physicians Signature: \_\_\_\_\_ Fax Form to 1-866-481-3704