

Prior Authorization Request  
Nevada Medicaid – OptumRx  
**Cesamet® (nabilone)**

**Submit fax request to:** 855-455-3303

**Purpose:** For a prescribing physician to request prior authorization for Cesamet® (nabilone)

**Questions:** If you have questions, call the OptumRx Call Center for Nevada Medicaid at 855-455-3311.

<b>DATE OF REQUEST:</b>		
<b>RECIPIENT INFORMATION</b>		
Last Name, First Name, Middle Initial:		Date of Birth:
Recipient ID:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Phone:
<b>PRESCRIBING PROVIDER INFORMATION</b>		
Name:	NPI:	Specialty:
Phone:	Fax (required):	
Person to contact regarding this request:		
<b>DIAGNOSIS AND REQUESTED DRUG</b>		
Applicable ICD-10 code and diagnosis <b>or</b> symptom/side effect ( <b>REQUIRED</b> ):		
Name: <b>Cesamet®</b>	Strength:	
Dosage:	Duration:	
<b>CLINICAL INFORMATION</b>		
<i>The following criteria must be met <u>and</u> documented in the recipient's medical record.</i>		
<b>Check the applicable boxes to indicate each item as true for the recipient:</b>		
<input type="checkbox"/> The recipient has a diagnosis of chemotherapy-induced nausea/vomiting		
<input type="checkbox"/> The recipient has experienced an inadequate response, adverse event, or has a contraindication to at least one serotonin receptor antagonist ( <i>please document below</i> )		
<input type="checkbox"/> The recipient has experienced an inadequate response, adverse event or has a contraindication to at least one other antiemetic agent ( <i>please document below</i> )		
<input type="checkbox"/> The prescriber is aware of the potential for mental status changes associated with the use of Cesamet® and will closely monitor the recipient		
<i>List the medications that were tried and failed for the given diagnosis:</i>		
<b>Drug Name</b>	<b>Reason for Failure</b>	<b>Date(s)</b>
_____	_____	_____
_____	_____	_____
Additional clinical information (if applicable):		
<b>PROVIDER CERTIFICATION – Prescriber's signature and date required.</b>		
<b>I hereby certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by Nevada Medicaid.</b>		
<b>Prescriber's Signature:</b> _____		<b>Date:</b> _____

*This authorization request is not a guarantee of payment. Payment is contingent upon eligibility, available benefits, contractual terms, limitations, exclusions, coordination of benefits and other terms and conditions set forth by the benefit program. The information on this form and on accompanying attachments is privileged and confidential and is only for the use of the individual or entities named on this form. If the reader of this form is not the intended recipient or the employee or agent responsible to deliver it to the intended recipient, the reader is hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If this communication is received in error, the reader shall notify sender immediately and destroy all information received.*