Prior Authorization Request
Nevada Medicaid – OptumRx

Marinol® (dronabinol)

Submit fax request to: 855-455-3303
Purpose: For a prescribing physician to request prior authorization for Marinol® (dronabinol)
Questions: If you have questions, call the OptumRx Call Center for Nevada Medicaid at 855-455-3311.

DATE OF REQUEST:		
RECIPIENT INFORMATION		
Last Name, First Name, Middle Initial:		Date of Birth:
Recipient ID:	Gender: ☐ Male ☐ Female	Phone:
PRESCRIBING PROVIDER INFORMATION		
Name:	NPI:	Specialty:
Phone:	Fax (required):	
Person to contact regarding this request:		
DIAGNOSIS AND REQUESTED DRUG		
Applicable ICD-10 code and diagnosis **or** symptom/side effect **(REQUIRED)**:		
Name:	Strength:	☐ Generic substitution not permitted
Dosage:	Duration:	

CLINICAL INFORMATION

The following criteria must be met and documented in the recipient's medical record.

Check the applicable boxes to indicate each item as true for the recipient:

- ☐ The recipient has a diagnosis of chemotherapy-induced nausea/vomiting
- ☐ The recipient has a diagnosis of AIDS-related anorexia associated with weight loss
- ☐ The recipient has experienced an inadequate response, adverse event, or has a contraindication to at least one serotonin receptor antagonist *(please document below)*
- ☐ The recipient has experienced an inadequate response, adverse event or has a contraindication to at least one other antiemetic agent *(please document below)*
- ☐ The recipient has experienced an inadequate response, adverse event or has a contraindication to megestrol (Megace®) *(please document below)*
- ☐ The prescriber is aware of the potential for mental status changes associated with the use of Marinol® (dronabinol) and will closely monitor the recipient

For requests for brand name Marinol® (dronabinol)

- ☐ The recipient has experienced an inadequate response, adverse event or has a contraindication to generic formulation of the requested medication *(please document below)*

List the medications that were tried and failed for the given diagnosis:

Drug Name	Reason for Failure	Date(s)
_____	_____	_____
_____	_____	_____

Additional clinical information (if applicable):

PROVIDER CERTIFICATION – *Prescriber's signature and date is required.*

I hereby certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by Nevada Medicaid.

Prescriber's Signature: _____ **Date:** _____