Prior Authorization Request
Hewlett Packard Enterprise – 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 Clinical Pharmacy Services 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-9 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:** _____

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.