

Request for Prior Authorization for Marinol (dronabinol)
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

All requests for Marinol (dronabinol) require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Marinol (dronabinol) Prior Authorization Criteria:

Coverage may be provided with a diagnosis of acquired immunodeficiency syndrome (AIDS) and the following criteria is met:

- Medication is being used for the treatment of anorexia associated with weight loss
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines
- **Initial Duration of Approval:** 12 months
- **Reauthorization criteria**
 - Documentation of significant improvement with treatment
- **Reauthorization Duration of Approval:** 12 months

Coverage may be provided with a diagnosis of cancer and the following criteria is met:

- Medication is being used for the treatment of nausea and vomiting associated with chemotherapy
- Must provide documentation showing the member has tried and failed (which will be verified via pharmacy claims if available) or had an intolerance or contraindication to a preferred conventional antiemetic treatment (e.g. ondansetron)
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines
- **Initial Duration of Approval:** 12 months
- **Reauthorization criteria**
 - Documentation of significant improvement with treatment
- **Reauthorization Duration of Approval:** 12 months

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

Drugs are authorized in generic form unless the branded product is on the preferred drug list or the prescriber has indicated in writing that the branded product is medically necessary. If only the branded product is on the preferred drug list, the generic form will be considered non-preferred and shall not require the prescriber to indicate in writing that the branded product is medically necessary.

**MARINOL (DRONABINOL)
PRIOR AUTHORIZATION FORM**

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX: (855) 476-4158**

If needed, you may call to speak to a Pharmacy Services Representative. **PHONE: (844) 325-6251 Mon – Fri 8 am to 7 pm**

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:
Member ID:	Member weight: Height:

REQUESTED DRUG INFORMATION

Medication:	Strength:
Directions:	Quantity: Refills:
Is the member currently receiving requested medication? <input type="checkbox"/> Yes <input type="checkbox"/> No Date Medication Initiated:	
Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Billing Information

This medication will be billed: <input type="checkbox"/> at a pharmacy OR <input type="checkbox"/> medically, JCODE: _____
Place of Service: <input type="checkbox"/> Hospital <input type="checkbox"/> Provider's office <input type="checkbox"/> Member's home <input type="checkbox"/> Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Diagnosis:	ICD Code:
For HIV, does the member have anorexia and weight loss? <input type="checkbox"/> Yes <input type="checkbox"/> No	
For Cancer, does the member have nausea and vomiting due to chemotherapy? <input type="checkbox"/> Yes <input type="checkbox"/> No	

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

REAUTHORIZATION

Has the member experienced improvement with treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature

Date

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