OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Cesamet®, Marinol® (dronabinol), Syndros® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:
❑ Anorexia with weight loss in patients with acquired immune deficiency syndrome (AIDS) [**Marinol (dronabinol) & Syndros** only]
❑ Nausea and vomiting in patients receiving cancer chemotherapy
❑ Other diagnosis: _____ ICD-10 Code(s): _____

Anorexia with weight loss in patients with AIDS:
Is the patient on antiretroviral therapy? ❑ **Yes** ❑ **No**
Is the patient unable to swallow capsules? ❑ **Yes** ❑ **No**
Is the patient unable to ingest a solid dosage form (e.g., oral tablet/capsule) due to age, oral/motor difficulties, or dysphagia? ❑ **Yes** ❑ **No**
Does the patient utilize a feeding tube for medication administration? ❑ **Yes** ❑ **No**
Select the medications the patient has a failure, contraindication, or intolerance to:
❑ Dronabinol capsule
❑ Megace (megestrol)

Nausea and vomiting in patients receiving cancer chemotherapy:
Is the patient unable to swallow capsules? ❑ **Yes** ❑ **No**
Is the patient unable to ingest a solid dosage form (e.g., oral tablet/capsule) due to age, oral/motor difficulties, or dysphagia? ❑ **Yes** ❑ **No**
Does the patient utilize a feeding tube for medication administration? ❑ **Yes** ❑ **No**
Select the medications the patient has a failure, contraindication, or intolerance to:
❑ Ativan (lorazepam)
❑ Compazine (prochlorperazine)
❑ Decadron (dexamethasone)
❑ Dronabinol capsule
❑ Haldol (haloperidol)
❑ Phenergan (promethazine)
❑ Reglan (metoclopramide)
❑ Zyprexa (olanzapine)
❑ A 5-HT3 receptor antagonist [e.g., Anzemet (dolasetron), Kytril (granisetron), Zofran (ondansetron)]

Quantity limit request:
What is the quantity being requested per DAY: _____
Is the patient receiving moderately to highly emetogenic chemotherapy? ❑ **Yes** ❑ **No**
Has the patient had at least a partial response to therapy at a dose within the quantity limit? ❑ **Yes** ❑ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

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