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 (Page 1 of 2)

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

Member Information (required)			**Provider Information** (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

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

Clinical Information (required)

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

Nausea and vomiting associated with cancer chemotherapy:

Will the requested medication be initiated within 2 hours of administration of chemotherapy AND continued for a period not to exceed 48 hours from that time? ❑ **Yes** ❑ **No**

Will the requested medication be used as a full therapeutic replacement for intravenous (IV) anti-emetic therapy that would have been administered at the time of the chemotherapy treatment? ❑ **Yes** ❑ **No**

Will the requested medication be used for continuation of therapy for treatment covered under Part B? ❑ **Yes** ❑ **No**

Anorexia with weight loss in patients with AIDS:

Is the patient on antiretroviral therapy? ❑ **Yes** ❑ **No**

Select the medications the patient has a failure, contraindication, or intolerance to:
- ❑ Anzemet
- ❑ Ativan (lorazepam)
- ❑ Compazine (prochlorperazine)
- ❑ Decadron (dexamethasone)
- ❑ Dronabinol capsule
- ❑ Granisetron tablet
- ❑ Haldol (haloperidol)
- ❑ Ondansetron
- ❑ Ondansetron orally disintegrating tablet (ODT)
- ❑ Phenergan (promethazine)
- ❑ Reglan (metoclopramide)
- ❑ Sancuso
- ❑ Syndros
- ❑ Zyprexa (olanzapine)
- ❑ Other 5HT-3 receptor antagonist (e.g., Aloxi, Zuplenz)

For Syndros requests, also answer the following:

Is the patient unable to swallow capsules? ❑ **Yes** ❑ **No**

Quantity limit request:

What is the quantity being requested per month: ________ Number of chemo cycles per month, if applicable:______

What is the reason for exceeding the plan limitations?
- ❑ Titration or loading-dose purposes
- ❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
- ❑ Requested strength/dose is not commercially available
- ❑ There is a medically necessary justification why the patient cannot use a higher commercially available strength to achieve the same dosage and remain within the same dosing frequency. **Please specify**: ____
- ❑ Other: ____

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Cesamet®, Marinol® (dronabinol), & Syndros®
Prior Authorization Request Form (Page 2 of 2)

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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.
If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.
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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