



Clinical and PDL Prior Authorization for Cannabinoid Antiemetics

Preferred	Non-Preferred, Prior Authorization Required
Marinol® (dronabinol)	Cesamet® (nabilone)

Beneficiary Information

Name: _____
 Medicaid ID #: _____ Date of Birth: _____

Pharmacy Information

Name: _____ Medicaid ID #: _____
 NPI #: _____ Phone #: _____ Fax #: _____
 Requested Drug: _____ NDC: _____

Prescriber Information

Name: _____ Medicaid ID #: _____
 NPI #: _____ Phone #: _____ Fax #: _____

Please check the appropriate box and provide the required information to receive the requested non-preferred drug.

PDL Non-Preferred Prior Authorization Information (required for non-preferred agents)

- Patient has a medical intolerance to preferred drug.** Please provide the name of the preferred drug and clinical symptoms of intolerance experienced by the patient: _____
- Patient has had an inadequate response to preferred drug.** Name of preferred agent patient tried: _____
- An appropriate formulation or indication is not available as a preferred drug.** Please specify which formulation or indication is needed and information supporting the need:

Initial Clinical Prior Authorization Information (required for all agents)

Please check the appropriate medication below and answer the specific questions:

- Cesamet
 - Does the patient have nausea and vomiting associated with cancer chemotherapy? YES No
 - Has the patient experienced inadequate response to conventional antiemetic treatment (i.e. 5-HT3 receptor antagonists, Anticholinergics, Antidopaminergics, etc.) YES No
- Marinol
 - Does the patient have intractable nausea associated with cancer chemotherapy? YES No
 - Does the patient have anorexia associated with weight loss in patients with AIDS? YES No
 - Is medication prescribed by or in consultation with one of these specialists? Oncologist YES No
 HIV specialist YES No



Kansas Medical Assistance Program

P O Box 3571
Topeka, KS 66601-3571
Provider 1-800-933-6593
Beneficiary 1-800-766-9012

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Criteria for Renewal of a Prior Authorization for Marinol

- Does the patient with AIDS wasting have continued wasting based on reductions of BMI? YES No
- Does the patient continue to have nausea associated with cancer chemotherapy? YES No

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

**The completed form should be faxed to the HPE Prior Authorization Unit at 1-800-913-2229.
This form will be returned unprocessed if it is not completed in its entirety.**