

DRONABINOL (MEDICARE DETERMINATION)

PHYSICIAN PRIOR AUTHORIZATION REQUEST FORM BlueCross[®] BlueShield[®] of South Carolina

Patient Information	
Name:	Insurance ID #:
Address:	Birthdate:

Provider Information	
Physician Name:	Physician DEA #:
Phone:	Fax:
Office Address:	
Diagnosis:	ICD-9 Code:

When this form is completed, please fax to Caremark at 888-836-0730.

This fax machine is located in a HIPAA-compliant, secure location. On behalf of BlueCross BlueShield of South Carolina, Caremark assists in the administration of prescription drug programs. Caremark is an independent company that provides pharmacy benefits management.

Call Caremark at 1-800-294-5979 with any questions concerning prior authorization procedures.

1. Is the patient receiving moderately to severely emetogenic chemotherapy?
[If the answer to this question is no, skip to question 3.] Y N
2. Has the patient tried and failed conventional antiemetic treatments [e.g., Compazine (prochlorperazine), Torecan (thiethylperazine), Phenergan (promethazine), Reglan IV (metoclopramide), and 5-HT₃ receptor antagonists [e.g., Anzemet (dolasetron), Kytril (granisetron), Zofran (ondansetron), and Aloxi (palonosetron)]?
[No further questions are required] Y N
3. Does the patient have a diagnosis of anorexia associated with weight loss in a patient with AIDs?
[If the answer to question is no, no further questions are required.] Y N
4. Has the patient been on Marinol therapy?
[If the answer to this question is no, skip to question 6.] Y N
5. Has the patient shown a positive response to treatment by maintaining or increasing their initial weight and/or muscle mass before initiating Marinol therapy?
[No further questions are required.] Y N
6. Has the patient had an involuntary weight loss of greater than 10% of pre-illness baseline body weight or body mass index (BMI) less than 20 kg/ml² in the absence of a concurrent illness of medical condition other than HIV infection that may cause weight loss? Y N

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Comments: _____

Information on this form is accurate as of the date below.

Prescriber's Signature:	Date:
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