



New Hampshire Medicaid Fee-for-Service Program Prior Authorization Drug Approval Form

Syndros® (dronabinol)

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME:

FIRST NAME:

MEDICAID ID NUMBER:

DATE OF BIRTH:

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GENDER: Male Female

Drug Name:

Strength:

Dosing Directions:

Length of Therapy:

SECTION II: PRESCRIBER INFORMATION

LAST NAME:

FIRST NAME:

SPECIALTY:

NPI NUMBER:

PHONE NUMBER:

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FAX NUMBER:

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SECTION III: CLINICAL HISTORY

1. Does the patient have a confirmed diagnosis of anorexia due to AIDS or chemotherapy-induced nausea and vomiting (CINV)? Yes No
2. Is the patient 18 years of age or older? Yes No
3. Is the patient unable to take dronabinol capsules? Yes No
If yes to question 3, list reason(s): _____
4. For AIDS wasting only - Has the patient tried, failed or is intolerant to megestrol acetate? Yes No
If yes to question 4, list date(s)/reason(s): _____
5. For CINV only – Has the patient tried, failed or is intolerant to 5HT₃ antagonist, neurokinin-1 (NK₁) antagonist or dexamethasone? Yes No
If yes to question 5, list date(s)/reason(s): _____
6. Has the patient had a documented adverse reaction to dronabinol or alcohol? Yes No
7. Is the patient currently on or has received disulfiram and or metronidazole containing products in the last 14 days? Yes No

Please provide any additional information that would help in the decision-making process. If additional space is needed, please use a separate sheet.

I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

PRESCRIBER'S SIGNATURE: _____ DATE: _____