

CESAMET (nabilone) PRIOR AUTHORIZATION FORM

- Please submit **all** requested documentation with this request. Incomplete documentation may delay the processing of this request.
- To review the prior authorization guidelines for Cesamet, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – **Antiemetics/Antivertigo Agents** and **Quantity Limits/Daily Dose Limits** (accessible at: <http://www.dhs.pa.gov/provider/pharmacyservices/index.htm>).

PRIOR AUTHORIZATION INFORMATION			PRESCRIBER INFORMATION		
<input type="checkbox"/> New request	<input type="checkbox"/> Additional info	# of pages in request:	Prescriber name:		
<input type="checkbox"/> Renewal request	PA# _____	_____			
Name of office contact:			Specialty:		
Contact's phone number:			State license #:		
LTC facility contact/phone:		NPI:	MA Provider ID#:		
RECIPIENT INFORMATION			Street address:		
Recipient Name:			Suite #:	City/state/zip:	
Recipient ID#:	DOB:	Phone:	Fax:		

CLINICAL INFORMATION

Medication requested: <input type="checkbox"/> Cesamet 1 mg capsule		
Dose/directions:	Quantity:	Refills:
Diagnosis (<i>submit documentation</i>):	DX code (<i>required</i>):	

INITIAL REQUESTS

1. Is the Recipient 18 years of age or older?	<input type="checkbox"/> Yes <input type="checkbox"/> No – <i>submit documentation supporting the use of Cesamet for the Recipient's age</i>
2. Is the Recipient receiving highly emetogenic chemotherapy or radiotherapy?	<input type="checkbox"/> Yes – <i>submit documentation</i> <input type="checkbox"/> No – <i>submit documentation supporting the use of Cesamet for the Recipient's diagnosis</i>
3. Does the Recipient have a history of trial and failure, contraindication, or intolerance of the preferred Antiemetic Agents? <i>Check all that apply.</i>	<input type="checkbox"/> Yes – <i>submit all supporting documentation of preferred agents tried and treatment outcomes, including contraindications or intolerances</i> <input type="checkbox"/> No
<input type="checkbox"/> Aloxi injection <input type="checkbox"/> ondansetron tablet/ODT/solution <input type="checkbox"/> dronabinol capsule <input type="checkbox"/> ondansetron injection vial/syringe <input type="checkbox"/> Emend capsule/pack <input type="checkbox"/> prochlorperazine tablet/suppository <input type="checkbox"/> Emend injection <input type="checkbox"/> promethazine tablet/syrup <input type="checkbox"/> granisetron injection <input type="checkbox"/> promethazine injection <input type="checkbox"/> metoclopramide tablet/solution <input type="checkbox"/> promethazine 12.5 mg/25 mg suppository <input type="checkbox"/> metoclopramide injection vial/syringe <input type="checkbox"/> Transderm Scop patch	
4. Does the Recipient have a history of trial and failure of Emend/aprepitant <u>in combination with Zofran/ondansetron</u> ?	<input type="checkbox"/> Yes – <i>submit documentation</i> <input type="checkbox"/> No

RENEWAL REQUESTS

1. Is the Recipient receiving highly emetogenic chemotherapy or radiotherapy?	<input type="checkbox"/> Yes – <i>submit documentation</i> <input type="checkbox"/> No – <i>submit documentation supporting the use of Cesamet for the Recipient's diagnosis</i>
2. Does the Recipient have documentation of success using Cesamet to treat or control nausea and vomiting?	<input type="checkbox"/> Yes – <i>submit documentation</i> <input type="checkbox"/> No

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	Date:
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