OPTIMA HEALTH PLAN

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: ***The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; fax to 1-800-750-9692. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. Incomplete form will delay authorization process.***

Drug Requested: **Syndros®** (dronabinol) **Oral Solution**

DRUG INFORMATION: ***Complete information below. If incomplete, authorization process will be delayed***

Drug Form/Strength/Quantity: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ ***ICD Code, if applicable*:** _____

CLINICAL CRITERIA: ***The criteria below MUST be met or authorization process will be delayed. Check applicable boxes below to qualify. Chart notes MUST be submitted to document trial and failure of prerequisite therapies:***

- ❑ **Patient is 18 years of age or older**

DIAGNOSES: ***Check diagnosis that applies. All criteria following diagnosis must be met for approval.***

❑ *Anorexia in patients with AIDS*

- ❑ Prescriber is an Infectious Disease provider specializing in HIV/AIDS treatment

AND

- ❑ Patient has a diagnosis of wasting syndrome due to AIDS

AND

- ❑ Patient has had a 30 day trial and failure of megestrol acetate

AND

- ❑ Patient has had trial and failure of at least three (3) months of dronabinol generic capsules titrated to maximum effective dose

❑ *Chemotherapy-induced nausea and vomiting*

- ❑ Prescriber is an Oncologist

AND

- ❑ Patient has a diagnosis of cancer with ongoing chemotherapy treatment

AND

- ❑ Patient has had insufficient response from combination treatment for acute/delayed chemotherapy-induced nausea/vomiting with standard treatment (such as ondansetron, dexamethasone or aprepitant). ***Please list therapies tried***:_____

AND

- ❑ Patient has had trial and failure of olanzapine for refractory nausea/vomiting

AND

- ❑ Patient has had 30-day trial and failure of dronabinol generic capsules titrated to maximum effective dose

OR

- ❑ Patient has difficulty swallowing capsules due to tumor resection or radiation therapy

(signature on next page)

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

***Approved by the Pharmacy and Therapeutics Committee:** 1/18/2018
REVISED/UPDATED: 3/6/2018