Please note: All information below is required to process this request.
Mon-Fri: 6am to 6pm Eastern / Sat: 6am to 6pm Eastern

# Syndros® Prior Authorization Request Form

**DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED**

| Member Information (required) | | | Provider Information (required) | | |
|---|---|---|---|---|---|
| Member Name: | | | Provider Name: | | |
| Insurance ID#: | | | NPI#: | Specialty: | |
| Date of Birth: | | | Office Phone: | | |
| Street Address: | | | Office Fax: | | |
| City: | State: | Zip: | Office Street Address: | | |
| Phone: | | | City: | State: | Zip: |

## Medication Information (required)

| Medication Name: | Strength: | Dosage Form: |
|---|---|---|
| ❑ Check if requesting **brand** | Directions for Use: | |
| ❑ Check if request is for **continuation of therapy** | | |

## Clinical Information (required)

**Select the diagnosis below:**

❑ Anorexia in patients with Acquired Immune Deficiency Syndrome (AIDS)

❑ Chemotherapy-induced nausea and vomiting

❑ Other diagnosis: _____ ICD-10 Code(s): _____

**Anorexia in patients with AIDS:**

Is the prescriber an infectious disease provider specializing in HIV/AIDS treatment? ❑ **Yes** ❑ **No**

Does the patient have wasting syndrome due to AIDS? ❑ **Yes** ❑ **No**

Has the patient had a 30 day trial and failure of megestrol acetate? ❑ **Yes** ❑ **No**

Has the patient had trial and failure of at least three (3) months of generic dronabinol capsules titrated to maximum effective dose? ❑ **Yes** ❑ **No**

**Chemotherapy-induced nausea and vomiting:**

Is the prescriber an oncologist? ❑ **Yes** ❑ **No**

Does the patient have cancer with ongoing chemotherapy treatment? ❑ **Yes** ❑ **No**

Has the patient had insufficient response from combination treatment for acute/delayed chemotherapy-induced nausea/vomiting with standard treatment (such as ondansetron, dexamethasone or aprepitant)? ❑ **Yes** ❑ **No**

Has the patient had trial and failure of olanzapine for refractory nausea/vomiting? ❑ **Yes** ❑ **No**

Has the patient had 30-day trial and failure of generic dronabinol capsules titrated to maximum effective dose? ❑ **Yes** ❑ **No**

Does the patient have difficulty swallowing capsules due to tumor resection or radiation therapy? ❑ **Yes** ❑ **No**

****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.***

**Prescriber Signature:** _____ **Date:** _____

**Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?**

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.