

**CAREFIRST - DC EXCHANGE 5T  
Dronabinol Post Limit (HMF)**

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at 888-836-0730. Please contact CVS/Caremark at 855-582-2022 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Dronabinol Post Limit (HMF).

**Patient Information**

**Patient Name:**

**Patient Phone:**  -  -

**Patient ID:**

**Patient Group No:**

**Patient DOB:**  /  /

**Prescribing Physician**

**Physician Name:**

**Physician Phone:**  -  -

**Physician Fax:**  -  -

**Physician Address:**

**City, State, Zip:**

**Drug Name (select from list of drugs shown)**

Dronabinol 10mg Capsule      Dronabinol 2.5mg Capsule      Dronabinol 5mg Capsule

**Quantity:** \_\_\_\_\_ **Frequency:** \_\_\_\_\_ **Strength:** \_\_\_\_\_

**Route of Administration:** \_\_\_\_\_ **Expected Length of Therapy:** \_\_\_\_\_

**Diagnosis:** \_\_\_\_\_ **ICD Code:** \_\_\_\_\_

**Comments:** \_\_\_\_\_

**Please check the appropriate answer for each applicable question.**

1. Is the requested drug being prescribed for nausea and vomiting associated with cancer chemotherapy?      **Y**       **N**
  2. Has the patient failed to respond adequately to a conventional antiemetic treatment?      **Y**       **N**
- [NOTE: Examples of conventional antiemetic therapies include dexamethasone, metoclopramide, olanzapine, prochlorperazine, and 5-HT3 receptor antagonists (e.g., Anzemet [dolasetron], granisetron, ondansetron)]
3. Does the patient require MORE than the plan allowance PER MONTH of 120 capsules of Marinol (dronabinol) or 240 milliliters (mL) of Syndros (dronabinol) oral solution?      **Y**       **N**

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

**Prescriber (Or Authorized) Signature and Date**

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