SENTARA HEALTH PLANS

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. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

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

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

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

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

Weight: _____ **Date:** _____

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ 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

(Continued on next page)

- ❑ 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

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.

***Approved by the Pharmacy and Therapeutics Committee:** 1/18/2018
REVISED/UPDATED: ~~3/6/2018;06/19/2019;~~**10/27/2023**