Pharmacy Prior Authorization

AETNA BETTER HEALTH FLORIDA

Marinol

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health Florida at **1-855-799-2554**.
When conditions are met, we will authorize the coverage of Marinol.
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(please circle)*

Marinol (dronabinol)

Other, please specify____

Quantity ___________ Frequency ________________ Strength ___________

Route of Administration ___________ Expected Length of therapy _______________

Patient Information

Patient Name: ____________________________________

Patient ID: ____________________________________

Patient Group No.: ____________________________________

Patient DOB: ____________________________________

Patient Phone: ____________________________________

Prescribing Physician

Physician Name: ____

Specialty: ____________________________ NPI Number: __________________________

Physician Fax: ____________________________ Physician Phone: __________________________

Physician Address: ____________________________ City, State, Zip: __________________________

Diagnosis:______________________________ **ICD Code:**______________________________

Please circle the appropriate answer for each question.

1. Does the patient have a diagnosis of anorexia due to AIDS? [If no, then skip to question 3.] Y N
2. Has the patient tried and failed or has a contraindication/intolerance to megestrol acetate? [No further questions.] Y N
3. Does the patient have a diagnosis of refractory chemotherapy-induced nausea and vomiting? [If no, then no further questions.] Y N

4. Does the patient have a current diagnosis of cancer or a history of cancer diagnosis within the previous 365 days? Y N
[If no, then no further questions.]

5. Is the patient currently receiving chemotherapy or has a history of chemotherapy within the previous 365 days? Y N
[If no, then no further questions.]

6. Has the patient failed to respond to conventional antiemetic therapies from the following classes: A) Corticosteroids: dexamethasone, B) Serotonin (5-HT3) Receptor Antagonists: ondansetron, C) Neurokinin-1 Receptor Antagonists: aprepitant (Emend)? Y N

Comments:

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I affirm that the information given on this form is true and accurate as of this date.

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Prescriber (Or Authorized) Signature **Date**