



**Marinol**  
(dronabinol)

**Express Scripts**  
**Prior Authorization**  
**Phone 800-417-8164**  
**Fax 877-837-5922**

**Please have the information below ready when calling in the authorization.**

Last Name	First Name
VH ID number	Date of Birth

Medication:	Diagnosis:
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<p><b>1. Is the patient undergoing chemotherapy?</b> <b>If NO, go to # 4</b></p>
<p><b>2. Has the patient tried and failed therapy with (including combinations of any of the two agents) Reglan (metoclopramide), Decadron (dexamethasone), Benadryl (diphenhydramine), Ativan (lorazepam), Inapsine (droperidol), or Torecan (thiethylperazine) for the nausea and vomiting associated with chemotherapy? Please specify name(s) of medications tried and failed, along with the dates the patient was on them.</b></p>
<p><b>3. Has the patient tried and failed one course of oral ondansetron/Zofran, Kytril or Anzemet?</b></p>
<p><b>4. Is the patient diagnosed with AIDS and suffering from AIDS-related anorexia?</b></p>
<p><b>5. Are there any other comments, diagnoses, symptoms, relevant lab values, and/or additional pertinent information that you feel is important to this review?</b></p>

Notice: **Failure to provide all information requested on this form may result in delayed processing or an adverse determination for insufficient information.** Our response time for prescription drug coverage requests is 72 hours. View our formulary and Prior Authorization forms online at <http://www.scanhealthplan.com>.