Member Name: ______________________________ Member ID: ________________ Member DOB: ________________

Drug Name: _____________________________ Strength: _______________ Directions: ______________________________________

Physician Name: __________________________ Physician Phone #: _________________________ Specialty: ______________________

Physician Fax #: _____________________ Pharmacy Name: ____________________________Pharmacy Phone: __________________

Horizon NJ Health

Dronabinol (Marinol, Syndros) and Nabilone (Cesamet) – Medical Necessity Request

*****Complete page 1 and 2 only for New/Initial requests*****

A. General Information:

1. **For Syndros or Cesamet requests only:** Can the prescription be changed to Marinol?
   - □ Yes: Please notify the pharmacy of the change and proceed to section B.
   - □ No: Please provide the clinical reason why Marinol cannot be tried, then proceed to section B.

   ____

B. Contraindication Information: Please indicate if the member has any of the listed contraindications for the requested drug.

Marinol	Syndros	Cesamet
□ History of a hypersensitivity reaction to sesame oil □ NONE	□ Sensitivity or history of hypersensitivity to alcohol □ Receiving or have received disulfiram- or metronidazole-containing products within the past 14 days □ NONE	□ History of hypersensitivity to any cannabinoid □ NONE

C. Additional Information:

- Current weight (from within the past 30 days): __________ lbs   Date Taken: ________
  __________ kg

- Height: ____________   Date Taken: ________

* please note for members younger than 18 years old, the height must be from within the past 30 days*

- Weight from 6 months ago: ___________ lbs or ___________ kg

D. Diagnosis Information (please indicate the reason for using the requested drug and answer related questions):

□ Anorexia/Weight Loss

- Does the member have HIV/AIDS? **Yes or No**

□ Nausea and Vomiting

- What is the nausea and vomiting associated with?
  - □ Cancer Chemotherapy
    - Has the member failed conventional antiemetic therapy (such as lorazepam, prochlorperazine, metoclopramide, dexamethasone, olanzapine, haloperidol, chlorpromazine, Kytril, Anzemet, and/or Zofran [ondansetron]?)
      - □ **Yes**
      - □ **No:** Please provide the clinical reason(s) why member has not failed conventional antiemetic therapy.

        ____
        ____
    - For Cesamet requests, is Cesamet being prescribed:
      - □ on a scheduled basis (patient will be taking Cesamet on a set schedule)
      - □ on an as needed (prn) basis (patient can take Cesamet any time the member is nauseous)
  - □ Other: ____

□ Other: ____

Physician office's signature*_________________________________ **Print Name**________________________________

***Form must be completed and signed by physician or licensed representative from the physician's office**

Member Name: ______________________________ Member ID: ________________ Member DOB: ________________

Drug Name: _____________________________ Strength: _______________ Directions: ______________________________________

Physician Name: __________________________ Physician Phone #: _________________________ Specialty: ______________________

Physician Fax #: _____________________ Pharmacy Name: ____________________________Pharmacy Phone: __________________

*****Complete page 2 only for Subsequent/Renewal requests*****

General Information:

- Current weight (from within the past 30 days): ________ lbs Date Taken: ________
________ kg
- Height : _____________ Date Taken: ________

* please note for members younger than 18 years old, the height must be from within the past 30 days*

Diagnosis Information:

□ Anorexia/Weight Loss associated with HIV/AIDS

□ Chemotherapy Induced Nausea and Vomiting (CINV)

□ Other: ______________________________________

Physician office's signature*________________________________ Print Name______________________________

***Form must be completed and signed by physician or licensed representative from the physician's office**