AmeriHealth Caritas™
New Hampshire

Syndros® (Dronabinol)

Prior Authorization Drug Approval Form

Date of medication request: (MM/DD/YYYY): ____ / ____ / _____

Patient information and medication requested	
Patient's name:	Medicaid number:
Date of birth:	Gender:
Drug name:	Strength:
Dosing directions:	Length of therapy:

Prescriber information			
Prescriber last name:		Prescriber first name:	
Prescriber address:		Prescriber representative:	
Specialty:		NPI number:	
Phone #:	Fax #:		

Clinical history
1. Does the patient have a confirmed diagnosis of anorexia due to AIDS or chemotherapy-induced nausea and vomiting (CINV)? ☐ Yes ☐ No
2. Is the patient 18 years of age or older? ☐ Yes ☐ No
3. Is the patient unable to take dronabinol capsules? ☐ Yes ☐ No If yes to question 3, list reason(s):
4. For AIDS wasting only — Has the patient tried, failed or is intolerant to megestrol acetate? ☐ Yes ☐ No If yes to question 4, list date(s)/reason(s):
5. For CINV only – Has the patient tried, failed or is intolerant to 5HT3 antagonist, neurokinin-1 (NK1) antagonist or dexamethasone? ☐ Yes ☐ No If yes to question 5, list date(s)/reason(s):
6. Has the patient had a documented adverse reaction to dronabinol or alcohol? ☐ Yes ☐ No
7. Is the patient currently on or has received disulfiram and or metronidazole containing products in the last 14 days? ☐ Yes ☐ No
Provide any additional information that would help in the decision-making process. If additional space is needed, please use a separate sheet.

Signature of prescriber:_____ Date: _____
(prescriber signature mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.