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**