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New Hampshire AIDS Drug Assistance Program (ADAP)
Prior Authorization Drug Approval Form

Syndros® (dronabinol)

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME:

FIRST NAME:

NH ADAP SOUNDEX ID NUMBER:

DATE OF BIRTH: – –

GENDER: ☐ Male ☐ Female

Drug Name:

Strength:

Dosing Directions:

Length of Therapy:

SECTION II: PRESCRIBER INFORMATION

LAST NAME:

FIRST NAME:

SPECIALTY:

NPI NUMBER:

PHONE NUMBER: – –

FAX NUMBER: – –

SECTION III: CLINICAL HISTORY

1. **Does the patient have a confirmed diagnosis of anorexia due to AIDS or chemotherapy-induced nausea and vomiti (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 $5HT_3$ antagonist, neurokinin-1 (NK_1) 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

Please provide any additional information that would help in the decision-making process. If additional space is needed, please use a separate sheet.

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.

PRESCRIBER'S SIGNATURE: _____ **DATE**: _____

Phone: 1-800-424-7901
Fax: 1-800-424-7984

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Magellan Rx MANAGEMENT℠