



Prior Authorization Form

**Arkansas Blue Cross and Blue Shield (Medicare)  
Medi-Pak Rx (PDP) and Medi-Pak Advantage (PFFS)  
Cesamet Post Limit (Medicare Determination)**

This fax machine is located in a secure location as required by HIPAA regulations.  
Complete/review information, sign and date. Fax signed forms to CVS|Caremark at 1-888-836-0730.  
Please contact CVS|Caremark at 1-800-294-5979 with questions regarding the prior authorization process.  
When conditions are met, we will authorize the coverage of Cesamet Post Limit (Medicare Determination).

**Drug Name (select from list of drugs shown)**

Cesamet (nabilone)

**Patient Information**

Patient

Name: \_\_\_\_\_

Patient ID: \_\_\_\_\_

Patient

Group No.: \_\_\_\_\_

Patient

DOB: \_\_\_\_\_

**Prescribing Physician**

Physician

Name: \_\_\_\_\_

Physician

Phone: \_\_\_\_\_

Physician

Fax: \_\_\_\_\_

Physician

Address: \_\_\_\_\_

City, State,

Zip: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

ICD

Code: \_\_\_\_\_

Please circle the appropriate answer for each applicable question.

- |  |   |   |
|--|---|---|
| 1. Did the patient have any IV antiemetic doses at the time of chemotherapy?   | Y | N |
| 2. Is this drug being used as part of a cancer chemotherapy regimen?   | Y | N |
| 3. Will the oral antiemetic formulation be used as a full therapeutic replacement for intravenous administration of the antiemetic drug within 48 hours of chemotherapy? | Y | N |
| 4. Will the patient require more than 48 hours (2 calendar days) of antiemetic therapy with this agent?  | Y | N |
| 5. Does the patient require more than the drug limitation of 20 capsules per 25 days?  | Y | N |
| 6. Is the patient receiving moderately to severely emetogenic chemotherapy?  | Y | N |
| 7. Has the patient tried and failed conventional antiemetic treatments?  | Y | N |

**Comments:** \_\_\_\_\_



**Arkansas  
BlueCross BlueShield**  
An Independent Licensee of the Blue Cross and Blue Shield Association

I affirm that the information given on this form is true and accurate as of this date.

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**Prescriber (Or Authorized) Signature and Date**