USAble Administrators

Physician's Prior Authorization Questionnaire
Marinol®

Patient: **ID#:** **DOB:**

Patient Address:

Marinol® is covered under certain clinical conditions. The following information will help determine if this patient is eligible for coverage of treatment with this drug.

1. What is the patient's diagnosis? *(Please do not use codes.)* ______________________________

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2. What dose of Marinol® is being requested? ______________________________
3. What is the expected duration of treatment? ______________________________
4. Please list previous medication(s) the patient has tried for this diagnosis:

Medication	Dose	Duration of Treatment

______________________________ ______________________________
Physician's Signature Date

______________________________ ______________________________
Please **Print** Physician's Name & Specialty Phone Number / Fax Number

Thank you for your assistance and should you have any questions or wish to discuss, please feel free to contact the pharmacy department at (501) 378-3392. For your convenience, you may fax your response(s) back to (501) 378-6980.

Forms are also available online at www.usableadmin.com/providers/PharmacyForms.aspx