

PRIOR AUTHORIZATION POLICY

- POLICY:** Dronabinol Prior Authorization Policy
- Marinol® (dronabinol capsules – AbbVie, generics)
 - Syndros® (dronabinol oral solution – Insys)

REVIEW DATE: 10/21/2020

OVERVIEW

Dronabinol capsules (Marinol®, generics) and Syndros® (dronabinol oral solution) are both indicated for anorexia associated with weight loss in patients with Acquired Immune Deficiency Syndrome (AIDS) and for nausea and vomiting associated with cancer chemotherapy in patients who have failed to respond adequately to conventional antiemetic treatments.^{1,2}

Dronabinol is an orally active cannabinoid which has complex effects on the central nervous system (CNS).^{1,2} The active ingredient is synthetic delta-9-tetrahydrocannabinol (delta-9-THC), which is a naturally occurring component of *Cannabis sativa L.* (e.g., marijuana). Dronabinol demonstrates reversible effects on appetite, mood, cognition, memory, and perception. These effects appear to be dose-related, increasing in frequency with higher dosages, and subject to great interpatient variability. Dronabinol capsules have not been studied in and are not recommended for pediatric patients with AIDS-related anorexia; caution is recommended in prescribing dronabinol capsules for children because of the psychoactive effects. The safety and effectiveness of Syndros have not been established in pediatric patients. Dronabinol is a controlled substance; the capsules are CIII and the oral solution is CII.

In addition to the FDA-approved uses for dronabinol, several Phase III studies have been completed or are underway according to clinicaltrials.gov; the disease states being studied include anorexia nervosa, chronic pain, multiple sclerosis, and opioid dependence.³ Published studies supporting these off-label uses are lacking.

Guidelines

The National Comprehensive Cancer Network (NCCN) guidelines regarding the treatment of emesis (version 2.2020 – April 23, 2020) include various regimens depending upon the emetogenic potential of the chemotherapy agent(s) being administered.⁴ Dronabinol is included in the list of medications for breakthrough nausea or emesis. Other recommended agents for breakthrough nausea or emesis include serotonin 5-HT₃ receptor antagonists, olanzapine, lorazepam, haloperidol, metoclopramide, scopolamine, prochlorperazine, promethazine, and dexamethasone. The agent should be from a different drug class to the current regimen, but no preference is given.

Safety

Dronabinol capsules contain sesame oil and are contraindicated in patients who are allergic to this substance.¹ Syndros is contraindicated in patients with a history of hypersensitivity to alcohol and patients who are receiving, or have recently received, disulfiram- or metronidazole-containing products within 14 days.² Syndros contains 50% (w/w) dehydrated alcohol and 5.5% (w/w) propylene glycol.

POLICY STATEMENT

Prior Authorization is recommended for prescription benefit coverage of dronabinol. All approvals are provided for the duration noted below. In cases where the approval is authorized in months, 1 month is equal to 30 days.

Automation: None.

RECOMMENDED AUTHORIZATION CRITERIA

A. Coverage of dronabinol capsules is recommended in those who meet the following criteria:

FDA-Approved Indications

1. Anorexia Associated with Weight Loss in Patients with Acquired Immune Deficiency Syndrome (AIDS): Approve for 6 months if ONE of the following criteria is met (A or B):

A) Generic dronabinol capsules are requested; OR

B) If brand Marinol is prescribed, the patient has tried generic dronabinol capsules AND the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction.

2. Nausea and Vomiting Associated with Cancer Chemotherapy in Patients who have Failed to Respond Adequately to Conventional Antiemetic Treatments: Approve for 1 year if the patient meets BOTH of the following criteria (A and B):

A) Patient has failed to respond adequately to at least two conventional antiemetic treatments; AND
Note: Examples of conventional antiemetic treatments include selective serotonin [5-HT₃] receptor antagonists [such as ondansetron, granisetron, Anzemet® {dolasetron}, Aloxi® {palonosetron injection}], Akynzeo® [netupitant/palonosetron capsules], Emend® (aprepitant capsules), Varubi™ (rolapitant tablets), metoclopramide, prochlorperazine, dexamethasone.

B) Patient meets ONE of the following criteria (i or ii):

i. Generic dronabinol capsules are requested; OR

ii. If brand Marinol is prescribed, the patient has tried generic dronabinol capsules AND the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction.

B. Coverage of Syndros is recommended in those who meet the following criteria:

FDA-Approved Indications

1. Anorexia Associated with Weight Loss in Patients with Acquired Immune Deficiency Syndrome (AIDS): Approve Syndros for 6 months if the patient meets ONE of the following criteria (A or B):

A) Patient has tried generic dronabinol capsules; OR

B) Patient cannot swallow or has difficulty swallowing capsules.

2. Nausea and Vomiting Associated with Cancer Chemotherapy in Patients who have Failed to Respond Adequately to Conventional Antiemetic Treatments: Approve Syndros for 1 year if the patient meets BOTH of the following criteria (A and B):

- A) Patient has failed to respond adequately to at least two conventional antiemetic treatments; AND
Note: Examples of conventional antiemetic treatments include selective serotonin [5-HT₃] receptor antagonists [such as ondansetron, granisetron, Anzemet® {dolasetron}, Aloxi® {palonosetron injection}], Akynzeo® [netupitant/palonosetron capsules], Emend® (aprepitant capsules), Varubi™ (rolapitant tablets), metoclopramide, prochlorperazine, dexamethasone.
- B) Patient meets ONE of the following (i or ii):
- i. Patient has tried generic dronabinol capsules; OR
 - ii. Patient cannot swallow or has difficulty swallowing capsules.

CONDITIONS NOT RECOMMENDED FOR APPROVAL

Coverage of dronabinol is not recommended in the following situations:

1. **Chronic Non-Cancer Pain.** Based on a review of published studies, there is insufficient evidence for the use of dronabinol in non-cancer pain due to the small study sizes and moderate to high risk of bias to allow for a definitive conclusion.⁵ In the two studies reviewed, the authors reported mixed effects for pain measures for dronabinol. More data are needed to define the place in therapy of dronabinol in the treatment of chronic non-cancer pain.
2. **Multiple Sclerosis.** Results from one published, randomized, double-blind, placebo-controlled study (n = 498) demonstrated that dronabinol has no overall effect on the progression of multiple sclerosis in patients with primary and secondary progressive multiple sclerosis.⁶ There is limited published evidence for the use of dronabinol in spasticity and pain in multiple sclerosis.⁷⁻⁸ An analysis of three studies in patients with spasticity due to multiple sclerosis found some improvement with dronabinol vs. placebo, but it did not reach statistical significance.⁷ A small study (n = 24) in patients with pain due to multiple sclerosis found that dronabinol had a modest analgesic effect, but adverse effects were also more frequent with dronabinol over placebo.⁸ A study in patients with multiple sclerosis and central neuropathic pain (n = 240) found no difference between dronabinol and placebo in pain intensity.⁹ More data are needed to define the place in therapy of dronabinol in the treatment of multiple sclerosis.
3. **Tourette's syndrome.** Published studies of dronabinol in patients with Tourette's syndrome are lacking.¹⁰ More data are needed to define the place in therapy of dronabinol in the treatment of Tourette's syndrome.
4. Coverage is not recommended for circumstances not listed in the Recommended Authorization Criteria. Criteria will be updated as new published data are available.

REFERENCES

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