DC | HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

# DC DOH-ADAP Informed Consent To Take Dronabinol Capsules (Marinol®) and Dronabinol Oral Solution (Syndros®)

Please initial each statement that you have read and discussed with your healthcare provider. Sign and date the completed form.

_____ I give informed consent to the ongoing use of dronabinol capsules/dronabinol oral solution for the treatment of my medical condition, anorexia associated with weight loss that has been unrelieved by other medications.

_____ I am making this decision after having the risks and benefits of using dronabinol use explained to me by my medical provider.

____ I acknowledge that the continued use of dronabinol may have some side effects.

_____ I will commit to the following processes to help make this treatment successful:

☐ Daily adherence to medication, unless told by prescriber/pharmacy to stop medication

☐ Medication Counseling, Education and Training regarding administration and side effects

☐ Telephone follow-ups with prescriber, pharmacy and insurance

☐ No missed follow-up appointments with prescriber during this treatment

_____ I understand that, if I am a woman of childbearing potential, the safety and efficacy of dronabinol has not been established in pregnancy. Dronabinol has the potential to cause harm to the unborn baby. I attest that I will have/have had a confirmed negative pregnancy test before starting treatment with dronabinol and that I will use effective contraception while receiving dronabinol treatment.

_____ I have been given an opportunity to ask questions about my condition, alternative treatment options and risk of treatment; I believe that I have enough information to understand the content of this disclosure and commitment to this treatment option.

_____ I understand that no warranty of guarantee has been made to me because of using this drug for my condition.

_____ I acknowledge that I have been given a copy of this completed consent form. I willingly give my commitment to the following regimen:

☐ **Dronabinol capsules** ____mg by mouth once daily before lunch and dinner. The dose may be adjusted by my Medical Provider if needed.

☐ **Dronabinol Oral solution** ____ mg by mouth twice daily (before lunch and dinner. The dose may be adjusted by my Medical Provider if needed.

Patient Name:_____ Patient Signature_____ Date: _____

Prescriber Signature: _____ Date_____

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Please fax completed form to Clinical Pharmacy Associates, Inc. **Fax #: 1-888-971-7229**
For any other questions, please call **1-800-745-0434 ext. 150**

Reviewed August 2018