

**OPTIMA HEALTH COMMUNITY CARE  
AND  
OPTIMA FAMILY CARE  
(MEDICAID)**

**PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST\***

**Directions:** The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; **fax to 1-800-750-9692.** No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. If information provided is **NOT** complete, correct, or legible, authorization will be delayed.

**Drug Requested:** Epidiolex® (cannabidiol) CV (Non-Preferred)

**DRUG INFORMATION:** Complete **all** information below or authorization will be delayed.

**Drug Form/Strength:** \_\_\_\_\_

**Dosing Schedule:** \_\_\_\_\_ **Length of Therapy:** \_\_\_\_\_

**Diagnosis:** \_\_\_\_\_ **ICD Code, if applicable:** \_\_\_\_\_

**CLINICAL CRITERIA.** Check below **ALL** that apply. **ALL** criteria **must** be met for approval. **ALL** documentation, including lab results and/or chart notes (**when required**), **must** be provided or request will be denied.

**Authorization Approval – One (1) Year**

Member must be  $\geq 2$  years of age

**AND**

Member diagnosed with Lennox-Gastaut syndrome (LGS) **OR** Dravet syndrome (DS)

**AND**

Prescribing physician is or has consulted with a neurologist or epileptologist appropriate for age

**\*\*Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.\*\***

**\*Previous therapies will be verified through pharmacy paid claims or submitted chart notes.\***

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

Member Optima #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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

Prescriber Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Office Contact Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

DEA OR NPI #: \_\_\_\_\_