OPTIMA HEALTH PLAN

PHARMACY/MEDICAL 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; **(Pharmacy) 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 the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Epidiolex® (cannabidiol)

DRUG INFORMATION: Complete information below or authorization will be delayed if incomplete.

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 labs or chart notes (if required) **must** be submitted or request will be denied.

For Initial 6-month approval - ALL of the following criteria must be met:.

- ❑ Patient must be 2 years of age or older

AND

- ❑ Prescribing Physician: ❑ Neurologist **OR** ❑ Consultation with a Neurologist

AND

- ❑ Patient must have **ONE** of the following diagnosis (**Please check patient's diagnosis below):**
  - ❑ Seizures associated with Lennox-Gastaut syndrome (LGS)

    OR

  - ❑ Seizures associated with Dravet syndrome (DS);

AND

- ❑ Patient must be refractory to at least 2 anti-epileptic drugs (AEDs) that are appropriate for diagnosis **(subject to verification through pharmacy paid claims):**
  - ❑ **AEDs for Lennox Gastaut:** (felbamate, valproate, topiramate, lamotrigine, rufinamide, clobazam, clonazepam, zonisamide)
  - ❑ **AEDs for Dravet Syndrome:** (valproate, clobazam, levetiracetam, topiramate, zonisamide, clonazepam)

AND

- ❑ Prescriber to provide attestation that Epidiolex® will be used be used in adjunct to $\geq$1 therapy with antiepileptic drugs

AND

(Continued on next page)

- ❑ Must submit baseline testing of serum transaminases (ALT and AST) and total bilirubin levels prior to starting therapy and monitored periodically throughout therapy

AND

- ❑ Prescriber to provide attestation that Epidiolex® will not be used with other cannabis or cannabis derivatives

Reauthorization – 12 months. **ALL** of the following criteria must be met:

- ❑ Patient continues to meet above criteria

AND

- ❑ Prescriber must submit annual serum transaminases (ALT and AST) and total bilirubin levels

AND

- ❑ There is no significant liver impairment (ALT or AST greater than 3 times upper limit of normal with bilirubin greater than 2 times upper limit of normal)

Medication being provided by Specialty Pharmacy - PropriumRx

*****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 #: ____

***Approved by Pharmacy and Therapeutics Committee**: 1/17/2019
REVISED/UPDATED: 3/20/2019