Please note: All information below is required to process this request.
Mon-Fri: 6am to 6pm Eastern / Sat: 6am to 6pm Eastern

Epidiolex® Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Dravet syndrome
❑ Lennox-Gastaut syndrome
❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Is Epidiolex prescribed by or in consultation with a neurologist? ❑ **Yes** ❑ **No**

Does the prescriber attest that Epidiolex will be used in adjunct to > 1 therapy with AEDs? ❑ **Yes** ❑ **No**

Will baseline testing of serum transaminases (ALT and AST) and total bilirubin levels prior to starting therapy be submitted and will levels be monitored periodically throughout therapy? ❑ **Yes** ❑ **No**
Please note: Chart documentation of the above is required to be submitted along with this fax.

Does the prescriber attest that Epidiolex will not be used with other cannabis or cannabis derivatives? ❑ **Yes** ❑ **No**

For Dravet syndrome, also answer the following:

Does the patient have seizures associated with Dravet syndrome (DS)? ❑ **Yes** ❑ **No**

Select if the patient is refractory to the following anti-epileptic drugs (AED):

❑ Clobazam	❑ Levetiracetam	❑ Valproate
❑ Clonazepam	❑ Topiramate	❑ Zonisamide

For Lennox-Gastaut syndrome, also answer the following:

Does the patient have seizures associated with Lennox-Gastaut syndrome (LGS)? ❑ **Yes** ❑ **No**

Select if the patient is refractory to the following anti-epileptic drugs (AED):

❑ Clobazam	❑ Felbamate	❑ Rufinamide	❑ Valproate
❑ Clonazepam	❑ Lamotrigine	❑ Topiramate	❑ Zonisamide

Reauthorization:

If this is a reauthorization, answer the following:

Is Epidiolex prescribed by or in consultation with a neurologist? ❑ **Yes** ❑ **No**

Does the prescriber attest that Epidiolex will be used in adjunct to > 1 therapy with AEDs? ❑ **Yes** ❑ **No**

Does the prescriber attest that Epidiolex will not be used with other cannabis or cannabis derivatives? ❑ **Yes** ❑ **No**

Will annual serum transaminases (ALT and AST) and total bilirubin levels be submitted? ❑ **Yes** ❑ **No**
Please note: Chart documentation of the above is required to be submitted along with this fax.

Is there significant liver impairment (ALT or AST greater than 3 times upper limit of normal with bilirubin greater than 2 times upper limit of normal)? ❑ **Yes** ❑ **No**

Epidiolex® Prior Authorization Request Form (Page 2 of 2)

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****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.

Prescriber Signature: _____ **Date:** _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.