Health Partners Medicare

PRIOR AUTHORIZATION REQUEST FORM

Epidiolex - Medicare

Phone: 215-991-4300 **Fax back to: 866-371-3239**

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Medicare	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Does the patient have a hypersensitivity to cannabidiol or any of the ingredients in the product?

☐ Yes ☐ No

Q2. Does the patient have a documented diagnosis of Dravet syndrome (DS) or Lennox-Gastaut syndrome (LGS) or Tuberous Sclerosis Complex (TSC)?

☐ Yes ☐ No

Q3. Is Epidiolex being prescribed by a neurologist or an epileptologist?

☐ Yes ☐ No

Q4. Is the patient 1 year of age or older?

☐ Yes ☐ No

Q5. Prior to initiation of therapy, are baseline serum transaminases (ALT and AST) and total bilirubin attached, and will these labs be monitored periodically during therapy?

☐ Yes ☐ No

Q6. Has the patient failed to become seizure-free with adequate trials of at least 2 antiepileptic drugs? (Document names of antiepileptic drugs tried, dates and duration.)

☐ Yes ☐ No

Q7. Will Epidiolex be used as adjunctive therapy with other antiepileptic drug(s) (provide name of drug or drugs)?

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q8. Is the requested Epidiolex dose in accordance with FDA-approved labeled dose not exceeding 20 mg/kg/day for treatment of seizures associated with Lennox-Gastaut Syndrome and Dravet Syndrome or dose not exceeding 25 mg/kg/day for treatment of seizures associated with Tuberous Sclerosis Complex?

☐ Yes ☐ No

Q9. Requested Duration:

☐ 12 months

Q10. Additional Information:

_____ _____

Prescriber Signature Date