FAX Completed Form To
1.877.386.4695

Provider Help Desk
1.866.399.0928

Request for Prior Authorization
Cannabidiol (Epidiolex)

PLEASE PRINT – ACCURACY IS IMPORTANT

IA Medicaid Member ID #	Patient name			DOB
Patient address				
Provider NPI		Prescriber name		Phone
Prescriber address				Fax
Pharmacy name	Address			Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.				
Pharmacy NPI		Pharmacy fax	NDC	

Prior authorization (PA) is required for cannabidiol (Epidiolex). Payment will be considered under the following conditions:

1) Patient meets the FDA approved age; and
2) Baseline serum transaminases (ALT and AST) and total bilirubin levels have been obtained prior to initiating therapy (attach results); and
3) A diagnosis of Lennox-Gastaut syndrome with documentation of an adequate trial and inadequate response with at least two concomitant antiepileptic drugs (AEDs) from the following: valproic acid, lamotrigine, topiramate, felbamate, rufinamide, clobazam; or
4) A diagnosis of Dravet syndrome with documentation of an adequate trial and inadequate response with at least two concomitant AEDs from the following: clobazam, valproic acid, levetiracetam, topiramate; and
5) Is prescribed by or in consultation with a neurologist; and
6) The total daily dose does not exceed 20mg/kg/day.

If criteria for coverage are met, initial requests will be approved for three months. Additional PA requests will be considered when the following criteria are met:

1) Documentation of clinical response to therapy (i.e. reduction in the frequency of seizures); and
2) The total daily dose does not exceed 20mg/kg/day.

The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Non-Preferred

Epidiolex ☐

Strength _____ Dosage Instructions _____ Quantity _____ Days Supply _____

Diagnosis: _____

Patient weight (kg): _____ **Date obtained:** _____

Request for Prior Authorizatio
Cannabidiol (Epidiolex) *(Continued)*

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Is prescriber a neurologist?

☐ Yes ☐ No If no, note consultation with neurologist:

Consultation date: _____ Physician name & phone: _____

Have baseline serum transaminases (ALT and AST) and total bilirubin been obtained prior to initiating therapy?

☐ Yes (attach results) ☐ No

☐ **Lennox-Gastaut syndrome**

Document an adequate trial and inadequate response with at least two concomitant AEDs from the following: valproic acid, lamotrigine, topiramate, felbamate, rufinamide, clobazam.

Trial #1 drug name and dose: _____

Trial dates: _____ Failure reason: _____

Trial #2 drug name and dose: _____

Trial dates: _____ Failure reason: _____

☐ **Dravet syndrome**

Document an adequate trial and inadequate response with at least two concomitant AEDs from the following: clobazam, valproic acid, levetiracetam, topiramate.

Trial #1 drug name and dose: _____

Trial dates: _____ Failure reason: _____

Trial #2 drug name and dose: _____

Trial dates: _____ Failure reason: _____

Renewals

Document clinical response to therapy: _____

Patient weight (kg): _____ **Date obtained:** _____

Prescriber signature (Must match prescriber listed above.)	Date of submission

IMPORTANT NOTE: *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.*