

## Request for Prior Authorization Cannabidiol (Epidiolex)

**FAX Completed Form To** 1 (800) 574-2515

**Provider Help Desk** 1 (877) 776-1567

	(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 info	ormation above. It must be legible, correct	, and complete or form will b	e returned.
Pharmacy NPI	Pharmacy fax	NDC	
Prior authorization (PA) is req conditions:	uired for cannabidiol (Epidiolex). Pay	ment will be considered u	nder the following
1) Patient meets the FDA app	proved age; and		
<ol><li>Baseline serum transamina therapy (attach results); an</li></ol>	ases (ALT and AST) and total bilirubin d	levels have been obtain	ed prior to initiating
,	staut syndrome with documentation of ant antiepileptic drugs (AEDs) from the namide, clobazam; or	•	•
, .	rome with documentation of an adequent the following: clobazam, valproic ac	•	•
5) Is prescribed by or in consu	ultation with a neurologist; and		
6) The total daily dose does n	ot exceed 20mg/kg/day.		
If criteria for coverage are me considered when the following	t, initial requests will be approved for g criteria are met:	three months. Additional	PA requests will be
•	esponse to therapy (i.e. reduction in t	he frequency of seizures)	; and
2) The total daily dose does n	ot exceed 20mg/kg/day.		
The required trials may be over medically contraindicated.	erridden when documented evidence	is provided that use of the	ese agents would be
Non-Preferred			
☐ Epidiolex			
Strength	Dosage Instructions	Quantity	Days Supply
Diagnosis:			
Patient weight (kg):	Date obtained:		

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## Request for Prior Authorization Cannabidiol (Epidiolex) (Continued)

(PLEASE PRINT - ACCURACY IS IMPORTANT)

Is prescriber a neurologist?		
☐ Yes ☐ No If no, note consultation w	rith neurologist:	
Consultation date:	_ Physician name & ph	one:
Have baseline serum transaminases (ALT atherapy?	nd AST) and total biliru	bin been obtained prior to initiating
☐ Yes (attach results) ☐ No		
☐ Lennox-Gastaut syndrome		
Document an adequate trial and inadequate revalproic acid, lamotrigine, topiramate, felbamat	•	<u> </u>
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 reclobazam, valproic acid, levetiracetam, topiram		concomitant AEDs from the following:
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 ab		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.

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