REALRx

PRIOR AUTHORIZATION REQUEST FORM
EPIDIOLEX®

For authorization, please answer each question and fax this form PLUS chart notes back to Real Rx at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance 385-425-5094.

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Epidiolex® (cannabidiol)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Is this request for an **expedited** review? By checking the **"Yes"** box to request an expedited review (24 hours), you are certifying that applying the standard review time frame (72 hours) may place the member's life, health, or ability to regain maximum function in serious jeopardy.	☐	☐	
2. Is the requesting provider a neurologist?	☐	☐	
3. Will Epidiolex® be used in combination with at least one anti-epileptic agent? (e.g. clobazam, felbamate, lamotrigine, levetiracetam, rufinamide, topiramate, valporic acid)?	☐	☐	**Please provide documentation**
4. Is the request for treatment of Lennox-Gastaut syndrome? If yes, has the diagnosis of Lennox-Gastaut syndrome been confirmed by a neurologist with both of the following: • Slow spike and wave electroencephalogram • Mixed seizure type	☐	☐	**Please provide documentation**
5. Is the request for Dravet syndrome? If yes, has the diagnosis of Dravet syndrome been confirmed by a neurologist with one of the following: • Age defined electroencephalogram finding with seizures • Genetic testing showing mutation for voltage-gated sodium channel, alpha-1 subunit (SCN1SA)	☐	☐	**Please provide documentation**

6. Is the request for Tuberous sclerosis complex? If yes, has the diagnosis of Tuberous sclerosis complex been confirmed by a neurologist with imaging of the brain?	☐	☐	**Please provide documentation**
7. For Lennox-Gastaut or Dravet syndrome, has the member tried and failed clobazam AND at least one of the following: • Banzel® (rufinamide). Note: requires prior authorization • clonazepam • carbamazepine • felbamate • lamotrigine • levetiracetam • oxcarbazepine • topiramate • valproic acid/valproate	☐	☐	**Please provide documentation**
8. For Tuberous Sclerosis Complex, has the member tried and failed at least one of the following: • Banzel® (rufinamide). Note: requires prior authorization • clonazepam • carbamazepine • felbamate • lamotrigine • levetiracetam • oxcarbazepine • topiramate • valproic acid/valproate • vigabatrin	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. For 1st reauthorization, has the member experienced a reduction in seizure activity of at least 25% compared to baseline?	☐	☐	**Please provide documentation**
3. For additional reauthorizations, has the member's seizure reduction been maintained?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			

Physician Signature:

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy: PHARM-024
Origination Date: 01/24/2019
Reviewed/Revised Date: 03/27/2024
Next Review Date: 03/27/2025
Current Effective Date: 04/01/2024

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