HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Epidiolex

Phone: 215-991-4300 **Fax back to: 866-240-3712**

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:**	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Address:	NPI:	Promise ID:
City, State ZIP:	*Prescriber PA PROMISe ID:*	
Patient Primary Phone:	Address:	
Line of Business: □ Medicaid		
□ CHIP	City, State ZIP:	
	Specialty/facility name (if applicable):	

□ Expedited/Urgent

Drug Name:
Strength:
Days Supply:
Number of Refills:
Directions / SIG:

HPP's maximum approval time is 12 months but may be less depending on the drug.

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 documented diagnosis of Dravet syndrome (DS) or Lennox-Gastaut syndrome (LGS)?

☐ Yes ☐ No

Q2. Is Epidiolex being prescribed by a neurologist or an epileptologist?

☐ Yes ☐ No

Q3. Is the patient 2 years of age and older?

☐ Yes ☐ No

Q4. 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

Q5. Is the patient currently receiving Epidiolex? (Attach dates and duration of current therapy).

☐ Yes ☐ No

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

☐ Yes ☐ No

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

☐ Yes ☐ No

Q8. Is the requested Epidiolex dose in accordance with FDA-approved labeled dose not to exceed 20 mg/kg/day?

☐ Yes ☐ No

Q9. Has the provider confirmed that the patient is not currently nor will be using recreational or medicinal cannabis while being treated with Epidiolex?

☐ Yes ☐ No

Q10. Requested Duration:

☐ 12 months

Q11. Additional Information:

Prescriber Signature ____________________ Date ____________________

Updated 2018

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