



HEALTH PARTNERS MEDICARE
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

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.

Form with two columns: Patient Name and Prescriber Name. Fields include Member Number, Date of Birth, Line of Business, Address, City, State ZIP, Primary Phone, Fax, Office Contact, NPI, State Lic ID, Address, City, State ZIP, and Specialty/facility name.

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 Tuberos 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? [Note: Attach baseline labs.]
Yes No

Q6. Has the patient failed to become seizure-free with adequate trials of at least 2 antiepileptic drugs? [Note: Document names of antiepileptic drugs tried, dates, and duration.]
Yes No

Q7. Will Epidiolex be used as adjunctive therapy with other antiepileptic drugs?

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party.



**HEALTH PARTNERS MEDICARE
PRIOR AUTHORIZATION REQUEST FORM**

Health Partners Plans

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:

[Note: Attach name of drug(s).]

Yes

No

Q8. Is the requested Epidiolex dose in accordance with FDA-approved labeled dose not to 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. Additional Information:

Q10. Requested Duration:

12 Months

Prescriber Signature

Date

2021 Medicare Prior Authorization Request