

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.**

<b>Patient Name:</b>	<b>Prescriber Name:</b>	
Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Line of Business: <input type="checkbox"/> Medicare	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	<b>Specialty/facility name (if applicable):</b>	

**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.**

<p>Q1. Does the patient have a hypersensitivity to cannabidiol or any of the ingredients in the product?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q2. Does the patient have a documented diagnosis of Dravet syndrome (DS) OR Lennox-Gastaut syndrome (LGS) OR Tuberous Sclerosis Complex (TSC)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q3. Is Epidiolex being prescribed by a neurologist or an epileptologist?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q4. Is the patient 1 year of age or older?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>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.]</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>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.]</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q7. Will Epidiolex be used as adjunctive therapy with other antiepileptic drugs?  [Note: List drug name (s) in #8 below.]</p>

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<b>Patient Name:</b>	<b>Prescriber Name:</b>
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q8. What adjunctive therapy will be used?	
Q9. 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?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q10. Additional Information:	
Q11. Requested Duration:	
<input type="checkbox"/> 12 Months	

Prescriber Signature

Date

2022 Medicare Prior Authorization Request