HEALTH PLANS
UNIVERSITY OF UTAH

PRIOR AUTHORIZATION REQUEST FORM
EPIDIOLEX®

For authorization, please answer each question and fax this form PLUS chart notes back to the U of U Health Plans Prior Authorization Department at 888-509-8142. Failure to submit clinical documentation to support this request will result in delay and/or denial of the request.

If you have prior authorization questions, please call for assistance: Healthy U: 855-856-5694, University of Utah Health Employees: 855-856-5690, Individual & Family Plans : 855-869-4769, Commercial Groups: 855-859-4892, MHC 855-885-7695

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 the request for Lennox-Gastaut syndrome?	☐	☐	
2. Has the diagnosis of Lennox-Gestaut syndrome been confirmed by a neurologist with both of the following: • Slow spike and wave electroencephalogram • Mixed seizure type	☐	☐	**Please provide documentation**
3. Is the request for Dravet syndrome?	☐	☐	
4. Has the diagnosis 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**
5. Has the member tried and failed at least one of the following: • felbimate • lamotrigine • topiramate • rufinamide • valproic acid • clonazepam	☐	☐	**Please provide documentation**
6. Has generic clobazam been tried and failed for at least 3 months, unless contraindicated?	☐	☐	**Please provide documentation**

REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Has the member experienced a reduction in seizure activity of at least 25% compared to baseline?	☐	☐	**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 delay and/or denial of the request****

Policy PHARM-024
Origination Date: 01/24/2019
Reviewed/Revised Date: 03/20/2019
Next Review Date: 03/20/2020
Current Effective Date: 03/20/2019