OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Epidiolex® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			**Provider Information** (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Continuation of therapy:
Is this request for a continuation of prior therapy for a seizure disorder? ❑ **Yes** ❑ **No**

Select the diagnosis below:
❑ Seizures associated with Dravet syndrome (DS)
❑ Seizures associated with Lennox-Gastaut syndrome (LGS)
❑ Other diagnosis: ______________________________ ICD-10 Code(s): ____

Prescriber specialty:
Was Epidiolex prescribed by or in consultation with a neurologist? ❑ **Yes** ❑ **No**

Clinical information:
Does the patient have a documented history of persisting seizures after titration to the highest tolerated dose with each medication trial? ❑ **Yes** ❑ **No**
Has lack of compliance as a reason for treatment failure been ruled out? ❑ **Yes** ❑ **No**
Is there documentation of failure due to intolerable side effects? ❑ **Yes** ❑ **No**
Were reasonable efforts made to minimize the side effects (e.g., change timing of dosing, divide dose out for more frequent but smaller doses, etc.)? ❑ **Yes** ❑ **No**

Medication history:
Select the medications the patient has a trial and failure, contraindication, or intolerance to:
❑ Divalproex
❑ Lamotrigine
❑ Topiramate
❑ Valproate
❑ Other anticonvulsant(s). Please specify: ____

For medications that are selected above as a trial and failure, please answer the following:
Were at least TWO of the selected medications tried for ≥ 8 weeks? ❑ **Yes** ❑ **No**

Reauthorization:
Is there documentation of a positive clinical response to Epidiolex therapy? ❑ **Yes** ❑ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?
____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of OptumRx. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**
Office use only: Epidiolex_Comm_2019Feb-W