



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 <small>(required)</small>			Provider Information <small>(required)</small>		
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 <small>(required)</small>			
Medication Name:		Strength:	Dosage Form:
<input type="checkbox"/> Check if requesting brand		Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy			

Clinical Information <small>(required)</small>
Continuation of therapy: Is this request for a continuation of prior therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, is it within the past 120 days? <input type="checkbox"/> Yes <input type="checkbox"/> No
Select the diagnosis below: <input type="checkbox"/> Seizures associated with Lennox-Gastaut syndrome (LGS) <input type="checkbox"/> Seizures associated with Dravet syndrome (DS) <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____
Prescriber specialty: Was the requested medication prescribed by or in consultation with a neurologist? <input type="checkbox"/> Yes <input type="checkbox"/> No
Select the medications the patient has a failure, contraindication, or intolerance to: <input type="checkbox"/> Lamotrigine <input type="checkbox"/> Topiramate <input type="checkbox"/> Valproate <input type="checkbox"/> Other anticonvulsant(s). Please specify: _____

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.
 If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.
 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.