Epidiolex

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-249-6155**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

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Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____
Request Initiated For: _____

1. What is the diagnosis?
   - ❑ Seizures associated with Lennox-Gastaut syndrome
   - ❑ Seizures associated with Dravet syndrome
   - ❑ Seizures associated with tuberous sclerosis complex
   - ❑ Other _____
2. What is the ICD-10 code? _____
3. What is the patient's weight? _____ kg or lbs ***(circle one)***
4. Has the patient been assessed with electroencephalography (EEG) or magnetic resonance imaging (MRI)? ***ACTION REQUIRED: If Yes, attach supporting medical records (i.e., chart notes, imaging report, or laboratory report) and indicate the date of EEG or MRI and skip to #6.***
   - ❑ Yes, MRI. Date: _____
   - ❑ Yes, EEG. Date: _____
   - ❑ No or Unknown
5. Does the patient have any of the following?
   ACTION REQUIRED: If Yes, attach supporting chart note(s) or medical record
   - ❑ A documented SCN1A gene mutation confirmed by genetic testing
   - ❑ A documented TSC1 or TSC2 gene mutation confirmed by genetic testing
   - ❑ None of the above
6. Is Epidiolex being prescribed by or in consultation with a neurologist? ❑ Yes ❑ No
7. Is the request for continuation of therapy with Epidiolex? ❑ Yes ❑ No *If No, skip to #10*
8. Is the patient currently receiving Epidiolex through samples or a manufacturer's patient assistance program? *If Yes or Unknown, skip to #10* ❑ Yes ❑ No ❑ Unknown
9. Has the patient achieved and maintained positive clinical response as evidenced by reduction in frequency or duration of seizures? ❑ Yes ❑ No *No further questions*

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization Fax: 1-866-249-6155

 Epidiolex SGM - 12/2020.

10. Has the patient received clinical assessments for seizures that include all of the following?
ACTION REQUIRED: If Yes, attach supporting chart note(s) or medical record. All of the following must be noted in the chart notes or reports. ❑ Yes ❑ No ❑ Unknown
A) Age at seizure onset, seizure types, and frequency of episodes
B) Review of risk factors, including other causes of seizures (e.g., other medical conditions and medications), family history, and developmental history

11. Has the patient had an inadequate response to prior therapy with at least one anti-epileptic drug?
ACTION REQUIRED: If Yes, attach supporting chart note(s) or medical record and specify the drug.
Examples of antiepileptic drugs include the following.
A) For Lennox-Gastaut syndrome: clobazam, felbamate, lamotrigine, levetiracetam, topiramate, rufinamide, valproate.
B) For Dravet syndrome: clobazam, levetiracetam, stiripentol, topiramate, valproate.
❑ Yes - Specify anti-epileptic drug tried: _____
❑ No

12. Will Epidiolex be used in combination with one or more anti-epileptic drugs?
ACTION REQUIRED: If Yes, attach supporting documentation. ❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

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