



Fax completed prior authorization request form to 800-854-7614 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned**

Pharmacy Coverage Guidelines are available at www.mercycareaz.org/providers/complecare-forproviders/pharmacy

Epidiolex Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.

REQUIRED: Office notes, labs and medical testing relevant to request showing medical justification to support diagnosis

Member Information								
Member Name (first & last):		Date of Birth:		Gender:		Height:		
				<input type="checkbox"/> Male <input type="checkbox"/> Female				
Member ID:		City:		State:		Weight:		
Prescribing Provider Information								
Provider Name (first & last):		Specialty:		NPI#		DEA#		
Office Address:		City:		State:		Zip Code:		
Office Contact:			Office Phone		Office Fax:			
Dispensing Pharmacy Information								
Pharmacy Name:			Pharmacy Phone:		Pharmacy Fax:			
Requested Medication Information								
Medication request is NOT for an FDA approved OR compendia-supported diagnosis (circle one): Yes No			Diagnosis:		ICD-10 Code:			
Are there any contraindications to formulary medications? If yes, please specify:					<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> New request	
<input type="checkbox"/> Continuation of therapy ONLY:	Has member had a decrease in seizure frequency from baseline?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Was serum transaminase level NOT >3 times ULN while accompanied by bilirubin > 2 times ULN?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Was serum transaminase level NOT sustained at >5 times ULN?					<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Directions for Use:			Strength:		Dosage Form:			
			Quantity:	Day Supply:	Duration of Therapy/Use:			
What medication(s) has the member tried and failed for this diagnosis? Please specify below.								
Turn-Around Time for Review								
<input type="checkbox"/> Standard – (24 hours)			<input type="checkbox"/> Urgent – waiting 24 hours for a standard decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision.					
Signature: _____								
Clinical Information								
Will Epidiolex be taken as adjunctive therapy to ONE other antiepileptic drug?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is prescribed dose appropriate for member's liver function AND does not exceed 20mg/kg/day?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Were serum transaminases AND total bilirubin levels obtained prior to start AND will be taken periodically as appropriate (per FDA approved labeling)?					<input type="checkbox"/> Yes	<input type="checkbox"/> No		
<input type="checkbox"/> Lennox-Gastaut Syndrome								
Has member tried AND failed OR has intolerance OR contraindication to Onfi (clobazam)?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Member had trial AND failure OR intolerance OR contraindication with TWO of the following:		<input type="checkbox"/> valproic acid	<input type="checkbox"/> topiramate	
						<input type="checkbox"/> felbamate	<input type="checkbox"/> lamotrigine	
<input type="checkbox"/> Dravet Syndrome								
Was there trial AND failure OR intolerance OR contraindication to Onfi (clobazam)?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Member had trial AND failure OR intolerance OR contraindication with ONE of the following?		<input type="checkbox"/> levetiracetam	<input type="checkbox"/> topiramate	
						<input type="checkbox"/> zonisamide	<input type="checkbox"/> lamotrigine	
						<input type="checkbox"/> felbamate		
Additional information prescribing provider feels is important to this review. Please specify below or submit medical records.								

[Empty box for notes or signature]

Signature affirms that information given on this form is true and accurate and reflects office notes.

Prescribing Provider's Signature: _____ Date: _____

Please note: Incomplete forms or forms without the chart notes will be returned

Office notes, labs, and medical testing relevant to the request that show medical justification are required.
Standard turnaround time is 24 hours. You can call 800-624-3879 to check the status of a request.