Updated: 10/2020
DMMA Approved: 10/2020

Request for Prior Authorization for Epidiolex (cannabidiol)
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

All requests for Epidiolex (cannabidiol) require a prior authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Epidiolex (cannabidiol) Prior Authorization Criteria:

For all requests for Epidiolex (cannabidiol) all of the following criteria must be met:

- Treatment is prescribed by, or in consultation with, a neurologist
- Medication must be used as adjunctive therapy with another antiepileptic drug
- Member must be 1 years of age or older
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines

Coverage may be provided with a diagnosis of Lennox-Gastaut syndrome and the following criteria is met:

- The member experienced at least 8 seizures in the last month while on stable antiepileptic drug therapy
- Must provide documentation showing the member has tried and failed (which will be verified via pharmacy claims if available) or had an intolerance or contraindication to all of the following:
    - Valproate
    - Lamotrigine
    - At least **one** of the following:
        - Rufinamide
        - Topiramate
        - Felbamate
        - Clobazam (requires prior authorization)
- **Initial Duration of Approval**: 6 months
- **Reauthorization criteria**:
    - Must provide documentation showing treatment with Epidiolex has provided improvement in the member's condition.
- **Reauthorization duration of approval**: 12 months

Coverage may be provided with a diagnosis of Dravet syndrome and the following criteria is met:

- The member experienced at least 4 convulsive seizures in the last month while on stable antiepileptic drug therapy.
- Must provide documentation showing the member has tried and failed (which will be verified via pharmacy claims if available) or had an intolerance or contraindication to all of the following:
    - Valproate

    - Clobazam (requires prior authorization)
    - Topiramate
    - At least **one** of the following:
        - Clonazepam
        - Levetiracetam
        - Zonisamide
- **Initial Duration of Approval**: 6 months
- **Reauthorization criteria**:
    - Must provide documentation showing treatment with Epidiolex has provided improvement in the member's condition.
- **Reauthorization duration of approval**: 12 months

Coverage may be provided with a diagnosis of Tuberous Sclerosis Complex and the following criteria is met:

- Member must have experienced the following over the past 4 weeks while on stable antiepileptic drug therapy:
    - At least 8 total seizures
    - At least 1 focal seizure occurring in at least 3 of the 4 weeks.
- Member must have tried and failed a ketogenic diet or provide patient-specific rationale for inappropriateness
- If member has a glioneuronal hamartoma or tuber, must have failed surgical management or provide patient-specific rationale for inappropriateness
- Must provide documentation showing the member has tried and failed (which will be verified via pharmacy claims if available) or had an intolerance or contraindication to at least one other antiepileptic drug and everolimus (requires prior authorization).
- **Initial Duration of Approval**: 6 months
- **Reauthorization criteria**:
    - Must provide documentation showing treatment with Epidiolex has provided improvement in the member's condition.
- **Reauthorization duration of approval**: 12 months

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

HIGHMARK. Delaware HEALTH OPTIONS

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CANNABIDIOL (EPIDIOLEX) (PAGE 1 of 2)
PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX:** (855) 476-4158
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (844) 325-6251 Monday through Friday 8:30am to 5:00pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:
Health Options ID:	Member weight: _____pounds or _____kg

REQUESTED DRUG INFORMATION

Medication:	Strength:
Frequency:	Duration:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:

Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? ☐ Yes ☐ No

Billing Information

This medication will be billed: ☐ at a pharmacy **OR**
☐ medically (if medically please provide a JCODE:_____

Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Does the member have a diagnosis of Lennox-Gastaut Syndrome, Dravet Syndrome or Tuberous Sclerosis Complex?
☐ Yes ☐ No

Number of seizures per month _____

Is the medication going to be used as adjunctive therapy to other antiepileptic drugs? ☐ Yes ☐ No

If member has a diagnosis of Tuberous Sclerosis Complex, please answer the following questions:

Is the member on a ketogenic diet? ☐ Yes ☐ No If not, please provide rationale for why this might be inappropriate:

If the member has a glioneuronal hamartoma or tuber, have they failed surgical management? ☐ Yes ☐ No

If not, please provide rationale for why this might be inappropriate:

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

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CANNABIDIOL (EPIDIOLEX) (PAGE 2 of 2) PRIOR AUTHORIZATION FORM	
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MEMBER INFORMATION	
Member Name:	DOB:
Health Options ID:	Member weight: _____pounds or _____kg
REAUTHORIZATION	
Has the member experienced a significant improvement with treatment? ☐ Yes ☐ No Please describe:_____ _____	
SUPPORTING INFORMATION or CLINICAL RATIONALE	
Prescribing Provider Signature	Date