Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Epidiolex
(cannabidiol)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication Requested: ☐ Epidiolex ICD10:

Strength & Dose: Quantity per month: Duration of therapy:

Is this a new start or continuation of therapy? If your patient has already begun treatment with drug samples of Epidiolex, please choose "new start of therapy". ☐ new start of therapy ☐ continued therapy
(if continued therapy) Has your patient had a positive clinical response with this drug (for example, a decrease in seizure frequency compared to baseline)? Please provide supportive documentation. ☐ Yes ☐ No
(if no) Please provide clinical support for continued use of this drug.

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

Clinical Information:

*****This drug requires supportive documentation (chart notes, test results, etc). Supportive documentation for all answers must be attached with this request*****

What is your patient's diagnosis?
☐ CDKL5 deficiency disorder
☐ cortical malformation/dysplasia
☐ Dravet syndrome
☐ Dup15q, Aicardi, or Doose syndromes
☐ epilepsy with myoclonic absences
☐ febrile infection-related epilepsy syndromes
☐ Lennox-Gastaut syndrome
☐ lissencephaly
☐ Sturge-Weber syndrome
☐ Tuberous Sclerosis Complex
☐ other (please specify):

Is your patient currently stabilized on the requested drug? ☐ Yes ☐ No
(if yes) Was your patient provided product samples? ☐ Yes ☐ No

(if Dravet syndrome, Lennox-Gastaut, deficiency disorder/syndromes/etc) Is Epidiolex being prescribed by, or in consultation with, a pediatric neurologist or an adult neurologist with expertise in epilepsy? ☐ Yes ☐ No

(if Dravet syndrome, Lennox-Gastaut) Has your patient had documented failure / inadequate response or is not a candidate for at least one other anti-epileptic drug (for example, clobazam, lamotrigine, rufinamide, topiramate, valproate)? ☐ Yes ☐ No

(if Dravet syndrome, Lennox-Gastaut) Will Epidiolex be used in combination with at least one anti-epileptic drug (for example, clobazam, lamotrigine, rufinamide, topiramate, valproate)? ☐ Yes ☐ No

(if Tuberous Sclerosis Complex) Does the patient have documented failure/inadequate response or is not a candidate for TWO anti-epileptic drugs (for example, valproic acid, lamotrigine, topiramate, clonazepam, levetiracetam, zonisamide, Banzel, felbamate, clobazam, Fycompa, vigabatrin, everolimus)? ☐ Yes ☐ No

(if Tuberous Sclerosis Complex) Is Epidiolex being prescribed by, or in consultation with, a neurologist? ☐ Yes ☐ No

(if deficiency disorder/syndromes/etc) Does the patient have documented failure/inadequate response or not a candidate for TWO anti-epileptic drugs (for example, valproic acid, lamotrigine, topiramate, clonazepam, levetiracetam, zonisamide, Banzel, felbamate, clobazam, Fycompa, vigabatrin)? ☐ Yes ☐ No

Additional pertinent information *(including prior therapy, disease stage, performance status, and names/doses/admin schedule of any agents to be used concurrently):*

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

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Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

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