Jefferson Health Plans

PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Epidiolex

Fax back to: (833) 605-4407
Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Exchange - PA	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Does the patient have a hypersensitivity to cannabidiol or any of the ingredients in the product?

☐ Yes ☐ No

Q2. Does the patient have documented diagnosis of Dravet syndrome (DS) or Lennox-Gastaut syndrome (LGS) or Tuberous Sclerosis Complex (TSC) with chart notes attached?

☐ Yes ☐ No

Q3. Is Epidiolex being prescribed by or in consultation with a neurologist?

☐ Yes ☐ No

Q4. Is the patient 1 year of age or older?

☐ Yes ☐ No

Q5. Has the patient failed to become seizure-free with at least 2 antiepileptic drugs (specify drugs tried) indicated to treat the patient's diagnosis?

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☐ Yes ☐ No

Q6. Will Epidiolex be used as adjunctive therapy with other antiepileptic drug(s) (provide name of drug or drugs)?

☐ Yes ☐ No

Q7. Is the requested dosing in accordance with recommended dosing guidelines for the treatment of the patient's diagnosis?

☐ Yes ☐ No

Q8. Additional Information:

_____ _____

Prescriber Signature Date

v2026

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