aetna™

Aetna Better Health®

Fax completed prior authorization request form to 844-802-1412 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 https://www.aetnabetterhealth.com/Illinois-medicaid

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: ☐ Male ☐ Female	Height:
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:			☐ Yes	☐ No	☐ New request	
☐ Continuation of therapy ONLY:	Has member had a decrease in seizure frequency from baseline?	☐ Yes ☐ No	Was serum transaminase level NOT >3 times ULN while accompanied by bilirubin > 2 times ULN?	☐ Yes	☐ No	
	Was serum transaminase level NOT sustained at >5 times ULN?			☐ Yes	☐ 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	
☐ Standard – (24 hours)	☐ **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?	☐ Yes	☐ No	Is prescribed dose appropriate for member's liver function AND does not exceed 20mg/kg/day?	☐ Yes	☐ No
Were serum transaminases AND total bilirubin levels obtained prior to start AND will be taken periodically as appropriate (per FDA approved labeling)?				☐ Yes	☐ No

☐ **Lennox-Gastaut Syndrome**					
Has member tried AND failed OR has intolerance OR contraindication to Onfi (clobazam)?	☐ Yes	☐ No	Member had trial AND failure OR intolerance OR contraindication with TWO of the following:	☐ valproic acid ☐ felbamate	☐ topiramate ☐ lamotrigine

☐ **Dravet Syndrome**

Was there trial AND failure OR intolerance OR contraindication to Onfi (clobazam)?	☐ Yes	☐ No	Member had trial AND failure OR intolerance OR contraindication with ONE of the following?	☐ levetiracetam	☐ topiramate
				☐ zonisamide	☐ lamotrigine
				☐ felbamate	

Additional information prescribing provider feels is important to this review. Please specify below or submit medical records.

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 866-329-4701 to check the status of a request.