Member Name: ____________________________ Member ID: _______________ Member DOB: _______________

Drug Name: ___________________________ Strength: ______________ Directions: ___________________________________

Physician Name: ________________________ Physician Phone #: _______________________ Specialty: ____________________

Physician Fax#: ____________________ Pharmacy Name: __________________________ Pharmacy Phone: _________________

Horizon NJ Health

Stiripentol (Diacomit) and Cannabidiol solution (Epidiolex) – ***Medical Necessity Request***

*****Complete page 1 for Initial Requests Only*****

Diagnosis Information (please indicate the diagnosis and answer the related questions):

□ Dravet syndrome (DS) □ Lennox-Gastaut syndrome (LGS)

□ Other ____________________________

General Questions:

1. Is the medication being prescribed by a neurologist or in consultation with a neurologist? **Yes** or **No**
2. Current weight _________lbs or ________kg
3. How many seizures does the member have in a month? ________________________
4. How many seizures has the member had while on antiepileptic treatment? ________________________
   *****Please submit chart documentation*****
5. What type of seizures did the member have? _________________________________
6. What other drugs has the member received in the past for this diagnosis?
   ____
   ____
7. Please provide the specific reason(s) these medications were stopped:
   ____
   ____
8. What other drugs will the member be receiving with the requested drug?
   ____
   ____

For Epidiolex requests:

1. Have the member's serum transaminases (ALT and AST) and total bilirubin been evaluated prior to starting treatment? **Yes** or **No**
   *****Please submit laboratory documentation*****
2. Will the member's serum transaminases (ALT and AST) and total bilirubin be monitored at 1 (one) month, 3 months, and 6 months after initiation of therapy? **Yes** or **No**

Physician office's signature*________________________________ Print Name_______________________________

***Form must be completed and signed by physician or licensed representative from the physician's office**

Member Name: _____________________________ Member ID: ________________ Member DOB: ________________

Drug Name: _____________________________ Strength: _______________ Directions: ______________________________________

Physician Name: __________________________ Physician Phone #: _________________________ Specialty: _____________________

Physician Fax#: _____________________ Pharmacy Name: ____________________________ Pharmacy Phone: __________________

****Complete page 2 only for Subsequent/Renewal requests****

1. What is the member's diagnosis?

   □ Dravet syndrome (DS) □ Lennox-Gastaut syndrome (LGS)

   □ Other ______________________________

2. Current weight _________ lbs or ________ kg

3. What other drugs will the member be receiving with the requested drug?
   ____
   ____

Physician office's signature*________________________________ Print Name_______________________________
***Form must be completed and signed by physician or licensed representative from the physician's office**