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 Date _____ (must be from within past 60 days).
3. How many seizures does the member have in a month? _____
4. What type of seizures did the member have? _____
5. What other drugs has the member received in the past for this diagnosis?

   _____

   _____
6. Please provide the specific reason(s) these medications were stopped:
   _____
   _____
7. 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**

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 Date _____ (must be from within past 60 days).

3. Has the member had any of the following:
   a. Decrease is seizure frequency from baseline **Yes or No**
   b. Stabilization in seizure frequency from baseline **Yes or No**

4. 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**