



Nevada Medicaid- Molina Healthcare

Epidiolex® (cannabidiol) Prior Authorization Request Form

Please provide the information below, please print your answer, attach supporting documentation, sign, date, and return to our office as soon as possible to expedite this request. Please FAX responses to: (844) 259-1689. Phone: (833) 685-2103.

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Molina ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
Directions for Use:		
<input type="checkbox"/> Check if request is for continuation of therapy		

Clinical Information (required)
<input type="checkbox"/> The recipient has a diagnosis of Lennox-Gastaut syndrome or Dravet Syndrome <input type="checkbox"/> The recipient is two years of age or older <input type="checkbox"/> A recent serum transaminase (ALT and AST) and total bilirubin level has been obtained and is within normal limits <input type="checkbox"/> The drug is prescribed by or in consultation with a neurologist <input type="checkbox"/> The total dose does not exceed 20 mg/kg/day (10mg/kg twice daily) <input type="checkbox"/> The medication will be used as adjunctive therapy (the recipient has been taking one or more antiepileptic drugs and has chart notes confirming the presence of at least four convulsive seizures per month)

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call (833) 685-2103.
This form may be used for non-urgent requests and faxed to (844) 259-1689.

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of Molina Healthcare. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**