

US Family Health Plan Prior Authorization Request Form for cannabidiol (**Epidiolex**)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:

Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Step 1 Please complete patient and physician information (please print):

Patient Name: _____ Address: _____ Sponsor ID #: _____ Date of Birth: _____	Physician Name: _____ Address: _____ Phone #: _____ Secure Fax #: _____
--	--

Step 2 Please complete the clinical assessment:

1. Is the requested medication being prescribed by a pediatric neurologist or neurologist?	<input type="checkbox"/> Yes proceed to question 2	<input type="checkbox"/> No STOP Coverage not approved
2. Has the patient been diagnosed with either Lennox-Gastaut Syndrome, Dravet Syndrome or tuberous sclerosis complex?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No STOP Coverage not approved

Step 3 I certify the above is true to the best of my knowledge. Please sign and date:

_____ Prescriber Signature	_____ Date
-------------------------------	---------------