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), Cannabidiol solution (Epidiolex), and Fenfluramine (Fintepla)– *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) □ Tuberous Sclerosis Complex (TSC)

□ 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**

For Fintepla requests:

1. Is the member currently receiving or has the member received a monoamine oxidase inhibitor (MAOI) within the past 14 days? **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) □ Tuberous Sclerosis Complex (TSC)

   □ 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**