

Cannabidiol Prior Authorization Program Summary

POLICY REVIEW CYCLE

Effective Date
11-01-2025

Date of Origin

POLICY AGENT SUMMARY PRIOR AUTHORIZATION

Target Brand Agent(s)	Target Generic Agent(s)	Strength	Targeted MSC	Available MSC	Final Age Limit	Preferred Status
Epidiolex	cannabidiol soln	100 MG/ML	M ; N ; O ; Y	N		

CLIENT SUMMARY – PRIOR AUTHORIZATION

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
Epidiolex	cannabidiol soln	100 MG/ML	IL HMO Performance Annual ; Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; NM HIM Annual 2024 ; NM HIM Annual 2025 ; NM HIM Annual 2026 ; NM Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods

PRIOR AUTHORIZATION CLINICAL CRITERIA FOR APPROVAL

Module	Clinical Criteria for Approval
	<p>Initial Evaluation</p> <p>Target Agent(s) will be approved when ALL of the following are met:</p> <ol style="list-style-type: none"> 1. The patient has a diagnosis of seizures associated with ONE of the following: <ol style="list-style-type: none"> A. Lennox-Gastaut syndrome (LGS) OR B. Dravet syndrome (DS) OR C. Tuberous sclerosis complex (TSC) AND 2. If the patient has an FDA labeled indication, then ONE of the following: <ol style="list-style-type: none"> A. The patient’s age is within FDA labeling for the requested indication for the requested agent OR

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	<p>B. There is support for using the requested agent for the patient's age for the requested indication AND</p> <p>3. The requested agent will NOT be used as monotherapy for seizure management AND</p> <p>4. The patient's medication history includes the use of an anticonvulsant in the past 90 days AND</p> <p>5. The prescriber submitted baseline liver transaminases and total bilirubin levels [medical records including lab results are required] upon initial review AND</p> <p>6. The prescriber will monitor the patient's liver transaminases while the patient is on the requested agent AND</p> <p>7. The prescriber is a specialist in the area of the patient's diagnosis (e.g., neurologist), or the prescriber has consulted with a specialist in the area of the patient's diagnosis AND</p> <p>8. The patient does NOT have any FDA labeled contraindications to the requested agent AND</p> <p>9. The requested quantity (dose) is within FDA labeled dosing for the requested indication</p> <p>Length of Approval:</p> <p>BCBSOK: 36 months</p> <p>ALL other plans: 12 months</p> <p>The requested agent will also be approved when ONE of the following is met:</p> <p>1. The request is for a BCBS NM Fully Insured or NM HIM member and ALL of the following:</p> <ul style="list-style-type: none"> A. The patient does NOT have any FDA labeled contraindications to the requested agent AND B. The requested indication is a rare disease AND C. ONE of the following: <ul style="list-style-type: none"> 1. The patient has another FDA labeled indication for the requested agent and route of administration OR 2. The patient has another indication that is supported in compendia for the requested agent and route of administration OR <p>2. ALL of the following:</p> <ul style="list-style-type: none"> A. The member resides in Ohio AND B. The plan is Fully Insured or HIM Shop (SG) AND C. The patient does NOT have any FDA labeled contraindications to the requested agent AND D. ONE of the following: <ul style="list-style-type: none"> 1. The patient has another FDA labeled indication for the requested agent and route of administration OR 2. The patient has another indication that is supported in compendia for the requested agent and route of administration OR 3. The prescriber has submitted TWO articles from major peer-reviewed professional medical journals [e.g., Journal of American Medical Association (JAMA), New England Journal of Medicine (NEJM), Lancet] supporting the proposed use(s) as generally safe and effective. Accepted study designs may include, but are not limited to, randomized, double blind, placebo controlled clinical trials. NOTE: Case studies are not acceptable [journal articles required] <p>Non-oncology compendia allowed: DrugDex level 1, 2A or 2B, AHFS-DI (narrative text must be supportive)</p> <p>Oncology compendia allowed: NCCN 1 or 2A, AHFS-DI (narrative text must be supportive), DrugDex level 1, 2A, or 2B, or Clinical Pharmacology (narrative text must be supportive), Lexi-Drugs evidence level A, peer-reviewed medical literature</p>

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	<p>Length of Approval:</p> <p>BCBSOK: 36 months</p> <p>ALL other plans: 12 months</p> <p>Renewal Evaluation</p> <p>Target Agent(s) will be approved when ALL of the following are met:</p> <ol style="list-style-type: none"> 1. The patient has been previously approved for the requested agent through the plan's Prior Authorization process [Note: patients not previously approved for the requested agent will require initial evaluation review] AND 2. The patient has had clinical benefit with the requested agent AND 3. The requested agent will NOT be used as monotherapy for seizure management AND 4. The prescriber is a specialist in the area of the patient's diagnosis (e.g., neurologist), or the prescriber has consulted with a specialist in the area of the patient's diagnosis AND 5. The patient does NOT have any FDA labeled contraindications to the requested agent AND 6. The requested quantity (dose) is within FDA labeled dosing for the requested indication <p>Length of Approval:</p> <p>BCBSOK: 36 months</p> <p>ALL other plans: 12 months</p>