Please see the sample language below to utilize for your rationale for coverage on behalf ofyour patient where PA criteria currently does not exist, or reimbursement decisions are made by medical exception only.This sample letter provides insight into what plans typically consider relevant information for you to include as a guide. Please note that some plans may require additional information.

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*{DateCreated}*

*{Provider\_Full\_Name}*

*{Site\_Address1} {Site\_Address2}*

*{Site\_City}, {Site\_State} {Site\_Zip}*

*{Contact Name} (Usually the medical director)*

*{Title}*

*{Name of the Health Insurance}*

*{Address Street}*

*{Address. City, State and Zip Code}*

Insured: *{Patient Name}*

Policy Number: *{Number}*

Group Number: *{Number}*

Dear Dr. *{Medical Director’s Name}*,

I am writing to you on behalf of my patient *{Patient Name}* to request reimbursement for EPIDIOLEX® (cannabidiol). *{Patient’s First Name’s}* plan does not cover EPIDIOLEX at this time, however, it is my professional opinion as a specialist that it is medically necessary for him/her. *{Patient’s First Name}* has been under my care since *[date]* for the treatment of *{Diagnosis}.*

Please see the attached documentation, regarding *{product name and/or patient’s first name}* to assist with your coverage decision.

* Include rationale why this is medically necessary at the dosage prescribed
* List all *{patient’s name}* previously tried and failed therapies (either for efficacy or tolerability)
* Include any pertinent diagnostic tests, such as EEG
* Provide reasons to substantiate why this would be the next logical step in your medical judgement to help the patient achieve better seizure control
* Include any pertinent medical records that support your decision to prescribe EPIDIOLEX
* Include published data that you feel supports EPIDIOLEX use for the patient’s condition
* Other considerations for inclusion:
	+ no other alternatives available or appropriate
	+ possible trial period of EPIDIOLEX to determine patient response to therapy, if coverage determinationis still pending with payer organization

Based upon the clinical rationale I have included, I request your approval of EPIDIOLEX as appropriate and medically necessary for my patient. If any further information is necessary for approval of this request, please feel free to call me at *{Prescriber’s phone number}* to discuss.

Thank you in advance for your immediate attention to this request so that I may move forward with treating this patient as I deem necessary for their health.

Sincerely,

*{Prescriber’s Signature}*

*{Prescriber’s Name}*