

**Prescriber Information**

Prescriber Name:		MD	DO	NP	PA	NPI:
Office Contact:		Practice Name / Collaborating MD:				
Address:		City:		State:		Zip:
Phone:	Fax:					

**Patient Information • PLEASE SEND COPY OF INSURANCE CARD**

Patients Name:	Last 4 Digits of SS#:	DOB: / /	Sex: M F	Weight:	Height:	Diabetic? Y N
Address:		City:		State:		Zip:
Home Phone:	Work/Cell:	HIPAA Contact:			Emergency #:	
Interpreter Needed? Y N	Allergies: Y N If Yes, list allergies:					

**Insurance Information**

Primary Insurance:	Policy ID:	Group #:	BIN:	PCN:
Policyholder Name:		Policyholder DOB: / /		

**Clinical Information • PLEASE SEND COPY OF MEDICAL AND PRESCRIPTION INSURANCE CARDS, PROGRESS NOTES AND LAB REPORTS, SUPPORTING DIAGNOSIS, CO-MORBIDITIES AND LAB VALUES**

ICD-10/Diagnosis Code:	Lennox-Gastaut Syndrome (G40.81)	Dravet Syndrome (G40.83)	Tuberous Sclerosis (Q85.1)	Other:
Has patient been previously treated for this condition? Y N Prior failed medication (medication and duration of treatment/ reason for d/c):				
Patient currently on therapy? Y N (List medication(s) below:)	Will patient be stopping above medication before starting new therapy? Y N			
Medication(s):	Is prescriber a neurologist? If no, include neurology consult if available. Y N Other:			
	Is patient pregnant, nursing or planning pregnancy? Y N N/A			
Serum creatinine:	Creatinine clearance:			

**Prescription Information**

Medication	Dose	Sig	Quantity	Refills
<b>Epidiolex®</b> (cannabidiol)	1mg/ml oral solution	<b>Dose Titration:</b>	QS for titration period	<b>No Refills</b>
		<b>Maintenance Dose:</b> Take ___ml (___mg) by mouth twice daily	30 day supply (in multiples of 60ml or 100ml)	
<b>Vigabatrin</b> (generic Sabril®)	500mg tablets 500mg packets for oral solution	<b>Dose Titration:</b>	QS for titration period	<b>No Refills</b>
		<b>Maintenance Dose:</b> Take ___mg by mouth twice daily	30 day supply	

By signing this form and utilizing our services, you are authorizing Meijer and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber Signature	Date	Prescriber Signature	Date
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Substitution Permitted

Dispense as Written

If brand is required, please write "DAW" in the box to the right.

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