Epidiolex (cannabidiol) for Lennox-Gastaut Syndrome (LGS)

EXCEPTION DRUG STATUS (EDS) REQUEST FORM

Fax: (204) 942-2030 or 1-877-208-3588

Prescriber Name:	**Fax Number:**
Prescriber Address:	**Phone Number:**
	Prescriber License Number (NOT Billing Number):

Patient First Name:	**PHIN:**	**MHSC:**
Patient Last Name:	**Patient's Date of Birth:**	

◯ **Initial Request** ◯ **Renewal Request**

Medication: Epidiolex (cannabidiol)	**Strength and Regimen:**	**Duration:**

Exception Drug Status (EDS) approval is only granted upon demonstration that the patient meets the coverage criteria of the EDS listing. Please provide the following details about how this patient meets the specific criteria for coverage. Manitoba Health may request additional documentation to support this EDS request.

For INITIAL Requests:

Diagnosis/Indication:	◯ For adjunctive treatment of seizures associated with Lennox-Gastaut Syndrome (LGS)
	◯ Other: _____

Please select YES or NO to the following statements.

The patient is 2 years of age or older.	◯ YES	◯ NO
The patient is under the care of a specialist with experience in the diagnosis and management LGS.	◯ YES	◯ NO
The patient has failed treatment with at least 2 anti-seizure medications.	◯ YES	◯ NO
The patient is currently taking 1 or more anti-seizure medication(s) at a stable dose for at least 4 weeks.	◯ YES	◯ NO
The patient has experienced at least 2 drop seizures **per week** in the past 28-day period. • Total number of drop seizures **per week** experienced in the past 28 days: _____	◯ YES	◯ NO
Will the patient be using cannabis products (recreational or medicinal) or other cannabinoid-based medications concurrently with Epidiolex?	◯ YES	◯ NO

Please provide the following details for the medications tried (as checked off above):

Anti-seizure Medications Tried	*Dosing Regimen Used*	*Start Date*	*End Date*	*Response to Trial*
				☐ Ineffective ☐ Intolerance (specify): ☐ Contraindication (specify): ☐ Other (specify):
				☐ Ineffective ☐ Intolerance (specify): ☐ Contraindication (specify): ☐ Other (specify):
				☐ Ineffective ☐ Intolerance (specify): ☐ Contraindication (specify): ☐ Other (specify):

For RENEWAL Requests:		
Please select YES or NO to the following statements.		
The patient continues to be under the care of a physician with experience in the diagnosis and management of LGS.	◯ YES	◯ NO
Is the patient concurrently using cannabis products (recreational or medicinal) or other cannabinoid-based medications?	◯ YES	◯ NO
Please provide proof of a beneficial clinical effect (as demonstrated by examples below):		
Please provide the total number of drop seizures **per week** experienced by the patient in the past 28 days: _____		
If applicable, please provide any other relevant information to support a beneficial clinical effect such as:		
Changes in the number of inpatient hospitalizations due to epilepsy:		
Changes in seizure severity:		
Other relevant information:		

Prescriber Signature and Date:	
☐ **I have discussed with the patient that the purpose of releasing their information to Manitoba Health, Seniors and Long-Term Care is to obtain Exception Drug Status for prescription coverage.**	
Date:	Prescriber Signature: