



AETNA BETTER HEALTH®  
Coverage Policy/Guideline

Name: Epidiolex

Page: 1 of 2

Effective Date: 2/3/2025

Last Review Date: 12/19/2024

Applies to: ☒ Florida Kids

☒ Pennsylvania Kids

**Intent:**

The intent of this policy/guideline is to provide information to the prescribing practitioner outlining the coverage criteria for Epidiolex under the patient's prescription drug benefit.

**Description:**

Epidiolex is indicated for the treatment of seizures associated with Lennox-Gastaut syndrome, Dravet syndrome, or tuberous sclerosis complex in patients 1 year of age and older.

All other indications are considered experimental/investigational and not medically necessary.

**Applicable Drug List:**

Epidiolex

**Policy/Guideline:**

**Criteria for Initial Approval:**

**A. Seizures associated with Lennox-Gastaut syndrome or Dravet syndrome**

1. Authorization may be granted for treatment of seizures associated with Lennox-Gastaut syndrome or Dravet syndrome in members 1 year of age and older;  
AND
  - a. For Lennox-Gastaut syndrome member is unable to take any 2 of the following due to a trial and inadequate treatment response or intolerance, or a contraindication: valproate derivative, lamotrigine, rufinamide, topiramate, or clobazam.
  - b. For Dravet syndrome: member is unable to take a valproate derivative and clobazam due to a trial and inadequate treatment response or intolerance, or a contraindication.

**B. Seizures associated with Tuberous Sclerosis Complex**

1. Authorization may be granted for treatment of seizures associated with tuberous sclerosis complex in members 1 year of age and older.

**Criteria for Continuation of Therapy:**

**A. Authorization may be granted for all members (including new members) who meet all of the following:**

1. The member meets ONE of the following
  - a. The member has a diagnosis of Lennox-Gastaut syndrome
  - b. The member has a diagnosis of Dravet syndrome
  - c. The member has a diagnosis of seizures associated with tuberous sclerosis complex



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2. The member is at least 1 year of age
3. The member has achieved and maintained positive clinical response as evidenced by reduction in frequency or duration of seizures compared with seizure activity prior to initiating Epidiolex.

#### Approval Duration and Quantity Restrictions:

**Initial and Renewal Approval:** 12 months

**Quantity Level Limit:** Epidiolex 100mg/mL oral solution: 800 mL per 30 days

#### References:

1. Epidiolex [package insert]. Palo Alto, CA: Jazz Pharmaceuticals, Inc.; January 2023.