NC Medicaid and NC Health Choice
Pharmacy Prior Approval Request for Epidiolex®

Beneficiary Information

01. Beneficiary Last Name: ______________________ 02. Beneficiary First Name: __________________________
03. Beneficiary ID #: ______________ 04. Beneficiary Date of Birth: ______________05. Beneficiary Gender: ____

Prescriber Information

06. Prescribing Provider NPI #: ____
07. Requester Contact Information:
Name: _______________________________ Phone #: ____________________ Ext. _____

Drug Information

08. Drug Name: _________________________ 09. Strength: ______________ 10. Quantity Per 30 Days: _______
11. Length of Therapy (in days): ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days ☐ 365 Days
☐ Other _____________

Clinical Information

Criteria for initial and reauthorizations requests:

01. Is the beneficiary 1 years of age or older? ☐ **Yes** ☐ **No**
02. Does the beneficiary have seizures associated with Lennox-Gastaut Syndrome (LGS) or Dravet Syndrome (DS)?
☐ **Yes** ☐ **No**

Signature of Prescriber: ____ Date:_________________________
(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to **1-800-678-3189**
Pharmacy PA Call Center: **1-866-799-5318**

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