AmeriHealth Caritas North Carolina

Pharmacy Request for Prior Approval – Epidiolex

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

Prescriber Information

6. Prescriber Name: _____ NPI #: _____
Mailing address: _____ City: _____ State: _____ ZIP: _____
7. Requester Contact Information: _____
Name: _____ Phone #: _____ Fax #: _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy: ___up to 30 days ___60 days ___90 days ___120 days ___180 days ___365 days ___Other:_____

Clinical Information

Initial Requests:

1. Is the beneficiary 1 years of age or older? Yes___ No___
2. Does the beneficiary have seizures associated with Lennox-Gastaut Syndrome (LGS) or Dravet Syndrome (DS)? Yes___ No___
3. Does the beneficiary have Tuberous Sclerosis Complex? Yes___ No___
4. Does the prescriber attest that the beneficiary's baseline serum transaminases (ALT and AST) and total bilirubin levels have been completed? Yes___ No___
5. Does the prescriber attest that beneficiary is not currently using recreational or medicinal cannabis along with this product? Yes___ No___
6. Does the prescriber attest that the beneficiary has refractory epilepsy (failed to become seizure-free with adequate trial of 2 antiepileptic drugs [AED])? Yes___ No___
7. Does the prescriber attest that Epidiolex will be used in adjunct to 1 or more antiepileptic drug(s)? Yes___ No___
(not required for reauthorization)

Reauthorization Requests (please answer questions 1-8):

8. Does the provider attest to monitoring beneficiary's annual serum transaminases (ALT and AST) and total bilirubin levels? 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: 1-877-234-4274, or call Pharmacy Prior Authorization: 1-866-885-1406