UnitedHealthcare Community Plan

NC Pharmacy Prior Approval Request for

Epidiolex

Beneficiary Information

1. Beneficiary Last Name: _____2. First Name: _____
3. Beneficiary ID #: _____4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: __

Prescriber Information

6. Prescribing Provider NPI #: _____ Provider Fax #: _____
7. Requester Contact Information - Name: _____ Phone #: _____Ext. _____

Drug Information

8. Drug Name:_____ 9. 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:

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

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.