Blue Cross® and Blue Shield® of North Carolina (Blue Cross NC) | Healthy Blue® | Healthy Blue® Care Together | Medicaid

Epidiolex Prior Authorization Form

Member Information		
1. Member last name:	2. Member first name:	
3. Member ID #:	4. Member date of birth:	5. Member gender:
Prescriber Information		
6. Prescribing provider NPI#:		
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 member 1 year of age or older? ☐ Yes ☐ No		
2. Does the member 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 **844-376-2318**
Healthy Blue Pharmacy PA Call Center: **844-594-5072**

https://provider.healthybluenc.com

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