

NC Pharmacy Prior Approval Request for Standard Drug Request Form

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 #: _____
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

1. Failed two preferred drug(s). If only one preferred drug is available, then failed one preferred drug.
List preferred drugs failed: _____
1a. Allergic Reaction 1b. Drug-to-drug interaction. Please describe reaction: _____

2. Previous episode of an unacceptable side effect or therapeutic failure. Please provide clinical information: _____

3. Clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to preferred drug(s).
Please provide clinical information: _____

4. Age specific indications. Please give patient age and explain: _____

5. Unique clinical indication supported by FDA approval or peer reviewed literature. Please explain and provide a general reference: _____

6. Unacceptable clinical risk associated with therapeutic change. Please explain: _____

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.