NC Medicaid and NC Health Choice
Pharmacy Prior Approval Request for
Hydroxychloroquine and Chloroquine

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

Request for Hydroxychloroquine – Please Indicate Diagnosis:

- ☐ Treatment of uncomplicated malaria due to P. falciparum, P. malariae, P. ovale, P. vivax
- ☐ Treatment of Chronic Discoid Lupus Erythematosus or Systemic Lupus Erythematosus in adults
- ☐ Prophylaxis of malaria in geographic areas where resistance to chloroquine is not reported
- ☐ Treatment of Rheumatoid Arthritis in adults

Request for Chloroquine – Please indicate Diagnosis:

- ☐ Treatment of uncomplicated malaria due to susceptible strains of P. falciparum, P. malariae, P. Ovale, P. vivax
- ☐ Treatment of extraintestinal amebiasis
- ☐ Prophylaxis of malaria in geographic areas where resistance to chloroquine is not reported

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.