



NC DMA Pharmacy Request for Prior Approval - Vusion



Recipient Information

DMA-3110 (V.01)

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

Payer Information

6. Is this a Medicaid or Health Choice Request? Medicaid: Health Choice:

Prescriber Information

7. Prescribing Provider #: _____ NPI: or Atypical:

8. Prescriber DEA #: _____

Requester Contact Information

Name: _____ Phone #: _____ Ext: _____

Drug Information

9. Drug Name: **Vusion** 10. Strength: _____ 11. Quantity Per 30 Days: _____

12. Length of Therapy (in days): up to 30 60 Other: _____

Clinical Information

1. Is the patient 4 weeks of age or older? Yes No

2. Has the patient tried and failed on at least 2 different prescription products from this list within the past 60 days:
nystatin cream, nystatin ointment, nystatin/triamconolone cream, nystatin/triamconolone ointment, or clotrimazole
cream?

Yes No

Please list products failed: _____

****Please note – a quantity limit of 50 gm per 60 days is in place****

Signature of Prescriber: _____ Date: _____

*Prescriber signature mandatory

Fax this form to CSC at: (855) 710-1969

Pharmacy PA Call Center: (866) 246-8505