NC Medicaid and NC Health Choice
Pharmacy Prior Approval Request for
Standard Drug Request Form

Beneficiary Information

1. Beneficiary Last Name: ____________________________ 2. First Name: ____________________________

Prescriber Information

6. Prescribing Provider NPI #: ____________________________
7. Requester Contact Information - Name: ____________________________ Phone #: ____________________________ Ext. ____________

Drug Information

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.

Fax this form to CSRA at (855) 710-1969
DHB Pharmacy 71

Pharmacy PA Call Center: (866) 246-8505
02/25/21