NC DHB Pharmacy Request for Prior Approval - Inhaled Corticosteroids and Combination Products

Recipient Information **DMA-0018 (V.03)**

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

9a. Drug Name: _____________________ 9b. Is this request for a Non-Preferred Drug? ☐ Yes ☐ No
10. Strength: ___________ 11. Quantity Per 30 Days: _____________
12. Length of Therapy (in days): ☐ up to 30 ☐ 60 ☐ 90 ☐ 120 ☐ 180 ☐ 365 ☐ 24 Months ☐ Other:_______

Clinical Information

No Prior Authorization Form Required for the Following Exemptions:
1. Pulmicort Respules (budesonide inhalation suspension) 0.25mg and 0.5mg do not require prior approval.
2. Children 4 years old up to 5 years old may use Flovent (fluticasone) without prior approval.

Request for Non-Preferred Drug:
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: ____________________________

Request for Inhaled Corticosteroids and Combination Products:
7. Does the patient have a documented 30-day trial and failure of QVAR? ☐ Yes ☐ No
8. Does the patient have a documented contraindication, intolerable side effects, or allergy to QVAR (beclomethasone dipropionate)?
☐ Yes ☐ No Please List: ____
9. Is the patient currently stable on long acting inhaled beta-agonist/steroid combination products for symptom control? ☐ Yes ☐ No
10. Is the patient diagnosed with COPD? ☐ Yes ☐ No
11. Does the patient have a documented 30-day trial and failure of an oral inhaled steroid product and require a long acting inhaled beta-agonist/steroid combination product? ☐ Yes ☐ No
12. Is the patient's condition severe enough to warrant a long acting inhaled beta-agonist/steroid combination product? ☐ 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 NCTracks at: (855) 710-1969 Pharmacy PA Call Center: (866) 246-8505