



NC DMA 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 CSC at: (855) 710-1969

Pharmacy PA Call Center: (866) 246-8505