NC Medicaid
Pharmacy Prior Approval Request for
Topical Antihistamines

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 10 Days

Clinical Information

Treatment for Atopic Dermatitis:

1. Has the beneficiary received previous treatment with at least one other topical antihistamine?
   ☐ Yes ☐ No
2. Has the beneficiary received previous treatment with at least two topical steroid creams? ☐ Yes ☐ No
3. Will the quantity be limited to 45 grams per 90 days? ☐ Yes ☐ No
4. Is this an initial authorization? Select 'Yes' for an initial authorization. Select 'No' for a reauthorization request. ☐ Yes ☐ No If answered no, please answer questions 4a and 4b
   4a. Have at least 3 months elapsed since the last time the beneficiary used the requested product?
   ☐ Yes ☐ No
   4b. Has the beneficiary benefited from therapy but remains at high risk? ☐ Yes ☐ No

** Please provide documentation that indicates the beneficiary has benefited from therapy but remains at high risk**

Treatment for Lichen Simplex Chronicus:

5. Has the beneficiary received previous treatment with at least two topical steroid creams? ☐ Yes ☐ No
6. Will the quantity be limited to 45 grams per 90 days? ☐ Yes ☐ No
7. Is this an initial authorization? Select 'Yes' for an initial authorization. Select 'No' for a reauthorization request. ☐ Yes ☐ No If answered no, please answer questions 7a and 7b
   7a. Have at least 3 months elapsed since the last time the beneficiary used the requested product?
   ☐ Yes ☐ No
   7b. Has the beneficiary benefited from therapy but remains at high risk? ☐ Yes ☐ No

** Please provide documentation that indicates the beneficiary has benefited from therapy but remains at high risk**

Signature of Prescriber: _____ Date: _____
(Prescriber Signature Mandatory)

Fax this form to CSRA at (855) 710-1969
Pharmacy PA Call Center: (866) 246-8505
DHB Pharmacy __

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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.