

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**

7. Prescribing Provider NPI #: \_\_\_\_\_  
8. Requester Contact Information  
Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Ext. \_\_\_\_\_

**Drug Information**

9. Drug Name: \_\_\_\_\_ 10. Strength: \_\_\_\_\_ 11. Quantity Per 10 Days: \_\_\_\_\_  
12. Length of Therapy (days):  10 days  Other: \_\_\_\_\_

**Clinical Information**

**Atopic Dermatitis**

1. Has the beneficiary received previous treatment with at least one other topical antihistamine?  Yes  No  
Please list other topical antihistamine tried \_\_\_\_\_  
2. Has the beneficiary received previous treatment with at least two topical steroid creams?  Yes  No  
Please list other topical steroid creams tried \_\_\_\_\_  
3. Is this request for a continuation of therapy?  Yes  No (must also answer questions 1 and 2 on continuation requests)  
3a. Have at least 3 months elapsed since the last time the beneficiary used the requested product?  Yes  No  
3b. (For continuation requests) Has documentation been attached to this request that indicates the beneficiary has benefited from therapy but remains at high risk?  Yes  No

**Lichen Simplex Chronicus**

1. Has the beneficiary received previous treatment with at least two topical steroid creams?  Yes  No  
Please list other topical steroid creams tried \_\_\_\_\_  
2. Is this request for a continuation of therapy?  Yes  No (must also answer question 1 on continuation requests)  
2a. Have at least 3 months elapsed since the last time the beneficiary used the requested product?  Yes  No  
2a. (For continuation requests) Has documentation been attached to this request that indicates the beneficiary has benefited from therapy but remains at high risk?  Yes  No

**\*\*Coverage limited to no more than 45 grams per 90 days**

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