

North Carolina Department of Health and Human Services
Division of Health Benefits
Eucrisa PA Request Form

Eucrisa

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. Med requested: **Eucrisa** 9a. Strength: _____ 9b. Quantity per 30 days _____
9c. Requested Duration _____
10. For areas OTHER than groin or face: Has the patient failed 2 generic topical corticosteroids in the highest potency class and is the patient greater than 2 years of age? Yes _____ No _____

11. For groin and face: Has the patient failed 2 topical generic corticosteroids from preferred list in any potency class (see criteria for list) AND is patient greater than 2 years of age? Yes _____ No _____

12. Does the patient have a documented adverse reaction or contraindication that precludes trial of 2 generic topical corticosteroids from preferred list (see criteria for list)? Yes _____ No _____

Please list: _____

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.

This form can be uploaded into the secure NCTracks Provider Portal, faxed, or mailed to NCTracks.

Fax all forms to NCTracks at: (855) 710-1969. Pharmacy PA Call Center: (866) 246-8505.