# NC DMA Pharmacy Request for Prior Approval - Vusion

**Recipient Information** **DMA-3110**

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**

9. Drug Name: **Vusion** 10. Strength: _____ 11. Quantity Per 30 Days: _____
12. Length of Therapy (in days): ☐ up to 30 ☐ 60 ☐Other:_____

**Clinical Information**

1. Is the patient 4 weeks of age or older? ☐ Yes ☐ No

2. Has the patient tried and failed on at least 2 different prescription products from this list within the past 60 days: nystatin cream, nystatin ointment, nystatin/triamconolone cream, nystatin/triamconolone ointment, or clotrimazole cream?

☐ Yes ☐ No

Please list products failed: _____

**Please note – a quantity limit of 50 gm per 60 days is in place**

Signature of Prescriber:_____ Date:_____

*Prescriber signature mandatory

Fax this form to CSC at: (855) 710-1964 Pharmacy PA Call Center: (866) 246-8505

Instructions for completing this form can be found at http://www.NCTracks.com/PAformhelp