

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

Prescriber Information

7. Prescriber Name: _____ NPI #: _____
Mailing address: _____ City: _____ State: _____ ZIP: _____
8. Requester Contact Information: _____
Name: _____ Phone #: _____ Fax #: _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy: ___ up to 30 days ___ 60 days ___ 90 days ___ 120 days ___ 180 days ___ 365 days ___ Other: _____

Clinical Information

1. Is the beneficiary 18 years of age or older? Yes ___ No ___
2. Is the beneficiary male? Yes ___ No ___
3. Does the beneficiary have a confirmed diagnosis of Benign Prostatic Hyperplasia? Yes ___ No ___
4. Is the beneficiary currently receiving an alpha blocker or nitrate? Yes ___ No ___
5. Please list the preferred medications for Benign Prostatic Hyperplasia from the NC Medicaid and Health Choice preferred drug list (PDL) that the beneficiary has tried and failed: _____

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.