AmeriHealth Caritas North Carolina

Pharmacy Request for Prior Approval – Non-Covered State Medicaid Plan Services Request Form for Recipients *under* 21 Years Old

Definitions of the Federal Medicaid services can be found in the Code of Federal Regulations 42 CFR 440.1-440.170 at:
https://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol4/pdf/CFR-2011-title42-vol4-sec440-170.pdf

This form is to be included with your Prior Authorization request for EPSDT consideration.
Include evidenced-based literature, if available.

Fax the completed form to Pharmacy Prior Authorizations at 1-877-234-4274 or mail to AmeriHealth Caritas North Carolina/PerformRx Pharmacy Services at 200 Stevens Drive, Philadelphia, PA 19113 c.c. 236.

Recipient Information: This must be completed by a physician, licensed clinician, or other provider.

Name: _____

Date of Birth: ____/____/_____ (mm/dd/yyyy) Medicaid ID Number: _____

Address: _____

_____

_____

Medical Necessity: All requested information, including CPT and HCPCS codes, if applicable, as well as provider information, must be completed. Please submit medical records that support medical necessity.

Requestor Name: _____

NPI: _____

Address : _____

_____

_____

Telephone: (___) ____-_____

Fax: (___) ____-_____

Provider Name: _____

NPI: _____

Address : _____

_____

_____

Telephone: (___) ____-_____

Fax: (___) ____-_____

Requested procedure, product, or service: _____

CPT/HCPCS code: _____/_____

In what capacity have you treated the recipient? (Include how long you have cared for the recipient and the nature of the care.)

_____

_____

_____

What is the recipient's health history? (Include chronic illness.)

_____

_____

_____

What is/are the recent diagnosis(es) related to this request? (Include the onset and course of the disease and the recipient's current status.)

_____

_____

_____

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What treatment has been given for the diagnosis(es) above? (Include previous and current treatment regimens, duration, treatment goals, and the recipient's response to treatment(s).)

_____
_____
_____

Please provide a description of how the requested procedure, product or service will correct or ameliorate the recipient's defect, physical or mental illness, or condition (the problem). This description *must* include a detailed discussion about how the service, product, or procedure will improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

_____
_____
_____
_____
_____
_____

Is this request for an experimental or investigational treatment? ☐ Yes ☐ No
If yes, provide name and protocol number: _____

Is the requested product, service, or procedure considered to be safe? ☐ Yes ☐ No
If no, please explain: _____
_____

Is the requested product, service or procedure effective? ☐ Yes ☐ No
If no, please explain: _____
_____

Are there alternatives to the product, procedure, or service requested that would be more cost effective but similarly medically effective? ☐ Yes ☐ No
If yes, specify what alternatives are appropriate for the recipient and provide evidence base with this request, if available:

_____
_____

What is the expected duration of treatment? _____
_____

Requestor's Signature & Credentials_____ Date: _____

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