AmeriHealth Caritas North Carolina

Pharmacy Request for Prior Approval – Standard Drug Request Form

Beneficiary Information

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

Prescriber Information

6. Prescriber Name: _____ NPI #: _____
Mailing address: _____ City: _____ State: _____ ZIP: _____
7. 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 ___270 days ___365 days

Clinical Information

1. __ Failed two preferred drugs. If only one preferred drug is available, then failed one preferred drug.
List preferred drugs failed: _____
1a. __ Allergic Reaction 1b. __ Drug-to-drug Interaction Please describe reaction: _____
_____
2. __ Previous episode of unacceptable side effect or therapeutic failure. Please provide clinical information: _____
_____
3. __ Clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to preferred drug(s).
Please provide clinical information: _____
4. __ Age specific indications. Please give patient age and explain: _____
_____
5. __ Unique clinical indication supported by FDA approval or peer reviewed literature.
Please explain and provide a general reference: _____
_____
6. __ Unacceptable clinical risk associated with therapeutic change. Please explain: _____
_____

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: 1-877-234-4274, or call Pharmacy Prior Authorization: 1-866-885-1406