AmeriHealth Caritas North Carolina

Pharmacy Request for Prior Approval – Topical Local Anesthetics

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 __365 days __Other: _____

Clinical Information

1. Is the beneficiary diagnosed with post-herpetic neuralgia? Yes___ No___
2. Does the beneficiary have a diagnosis of neuropathic pain? Yes___ No___ **IF YES, please answer 2a.**
   2a. Does the recipient have a documented trial and failure of at least two of the following drug categories:
   Tri-cyclic antidepressants, SSRIs, SNRIs, anticonvulsants, NSAIDs, or COXIIs or have a documented clinical reason that these products cannot be tried? Yes___ No___
   List drugs tried: _____
3. Does the beneficiary have a diagnosis of chronic musculoskeletal pain of greater than 6 months in duration?
   Yes___ No___ **If YES, please answer 3a.**
   3a. Does the recipient have a documented trial and failure of at least two of the following drug categories:
   Tri-cyclic antidepressants, SSRIs, SNRIs, anticonvulsants, NSAIDs, or COXIIs or have a documented clinical reason that these products cannot be tried? Yes___ No___
   List drugs tried: _____

For Non-preferred medication requests:

4. Has the beneficiary tried and failed a preferred topical neuropathic pain medication? Yes___ No___

List:_____

For continuation: (answer in addition to the questions above)

5. Has the beneficiary shown continued benefit and improvement or stability in functional status? Yes___ No___
(Must include documentation)

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