AmeriHealth Caritas North Carolina

Pharmacy Request for Prior Approval – Vusion

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

Clinical Information

1. Is the beneficiary at least four weeks of age? 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/triamcinolone cream, nystatin/triamcinolone ointment, or clotrimazole cream?

Yes___ No___ If Yes, 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**

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