NC Medicaid and NC Health Choice
Pharmacy Prior Approval Request for
Topical Antihistamines

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____5. Beneficiary Gender: ____

Prescriber Information

6. Prescribing Provider NPI #: _____
7. Requester Contact Information - Name: _____ Phone #: _____ Ext. _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy (in days): ☐ up to 10 days

Clinical Information

Treatment for Atopic Dermatitis:

1. Has the beneficiary received previous treatment with at least one other topical antihistamine? ☐ **Yes** ☐ **No**
2. Has the beneficiary received previous treatment with at least two topical steroid creams? ☐ **Yes** ☐ **No**
3. Will the quantity be limited to 45 grams per 90 days? ☐ **Yes** ☐ **No**
4. Is this an initial authorization? Select 'Yes' for an initial authorization. Select 'No' for a reauthorization request.
   ☐ **Yes** ☐ **No** If answered no, please answer questions 4a and 4b
   4a. Have at least 3 months elapsed since the last time the beneficiary used the requested product? ☐ **Yes** ☐ **No**
   4b. Has the beneficiary benefited from therapy but remains at high risk? ☐ **Yes** ☐ **No** ** Please provide documentation that indicates the beneficiary has benefited from therapy but remains at high risk**

Treatment for Lichen Simplex Chronicus:

5. Has the beneficiary received previous treatment with at least two topical steroid creams? ☐ **Yes** ☐ **No**
6. Is this an initial authorization? Select 'Yes' for an initial authorization. Select 'No' for a reauthorization request.
   ☐ **Yes** ☐ **No** If answered no, please answer questions 6a and 6b
   6a. Have at least 3 months elapsed since the last time the beneficiary used the requested product? ☐ **Yes** ☐ **No**
   6b. Has the beneficiary benefited from therapy but remains at high risk? ☐ **Yes** ☐ **No** ** Please provide documentation that indicates the beneficiary has benefited from therapy but remains at high risk**

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 CSRA at (855) 710-1969
DHB Pharmacy 73

Pharmacy PA Call Center: (866) 246-8505
02/11/2021