NC Medicaid and NC Health Choice
Pharmacy Prior Approval Request for
Epinephrine Products

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 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days ☐ 365 Days ☐ Other ________

Clinical Information

Preferred Products:

1. Is the requested quantity for more than 6 pens per 180 days? ☐ **Yes** ☐ **No**
2. Prescriber please submit reasoning for medical necessity of the quantity limit exceeding the allowable maximum of six (6) pens. ____
____
____

Non-Preferred Products:

1. ☐ Failed two preferred drug(s). 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 an 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: ______________________
   ____
7. Is the requested quantity for more than 6 pens per 180 days? ☐ **Yes** ☐ **No**
8. Prescriber please submit reasoning for medical necessity of the quantity limit exceeding the allowable maximum of six (6) pens. ____
____
____

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 Pharmacy PA Call Center: (866) 246-8505