NC Medicaid and NC Health Choice
Pharmacy Prior Approval Request for

Topical Anti-Inflammatories

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

1. Has the beneficiary tried and failed on at least one prescription topical corticosteroid**?** ☐ **Yes** ☐ **No**
2. Does the beneficiary have a documented adverse reaction or contraindication that precludes trial of 1 topical corticosteroid? ☐ **Yes** ☐ **No Please List:** _____

For Non-preferred medication Requests:

3. Has the beneficiary tried and failed any preferred topical anti-inflammatory medications? ☐ **Yes** ☐ **No**
4. Please list any failed medications or contraindications: _____
   _____

Please answer the following depending on the Topical Anti-inflammatory being requested:

5. Eucrisa: Is the beneficiary 3 months old or older? ☐ **Yes** ☐ **No**
6. Elidel, Pimecrolimus cream, Protopic 0.03%, and Tacrolimus 0.03%: Is the beneficiary 2 years of age or older? ☐ **Yes** ☐ **No**
7. Protopic 0.1% and Tacrolimus 0.1%: Is the beneficiary 18 years of age or older? ☐ **Yes** ☐ **No**

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.