



**NC DHB Pharmacy Request for Prior Approval
Non-Steroidal Anti-Inflammatory Drugs including Cox-2 Inhibitors**

Recipient Information

1. Recipient Last Name: _____ 2. First Name: _____
3. Recipient ID # _____ 4. Recipient Date of Birth: _____ 5. Recipient Gender: _____

Payer Information

6. Is this a Medicaid or Health Choice Request? Medicaid: Health Choice:

Prescriber Information

7. Prescribing Provider #: _____ NPI: or Atypical:
8. Prescriber DEA #: _____

Requester Contact Information

Name: _____ Phone #: _____ Ext: _____

Drug Information

9. Drug Name: _____ 10. Strength: _____ 11. Quantity Per 30 Days: _____
12. Length of Therapy (in days): up to 30 60 90 120 180 Other: _____

Clinical Information

1. Is the patient being treated for pain (acute or chronic)? Yes No
2. Does the patient have a documented history of GI Bleed, Gastric Ulcer, or Duodenal Ulcer? Yes No
3. Is the patient receiving a systemic (oral or parenteral) corticosteroid? Yes No
4. Does the patient have a history of Platelet Dysfunction or Coagulopathy? Yes No
5. Does the patient have a diagnosis of Familial Adenomatous Polyposis (FAP)? Yes No
6. Does the patient have a previous intolerance to at least 2 non-COX 2 classes of NSAIDs at therapeutic doses? Yes No

If requesting a non-preferred medication, answer question #7

7. Has the patient tried and failed on a preferred medication? Yes No

Please list preferred tried: _____

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: (800) 678-3189

Pharmacy PA Call Center: (866) 799-5318