NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

WellCare
Beyond Healthcare. A Better You.

NC DHB Pharmacy Request for Prior Approval
Standard Drug Request Form

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: _____ 9b. Is this request for a Non-Preferred Drug? ☐ Yes ☐ No

10. Strength: _____ 11. Quantity Per 30 Days: _____

12. Length of Therapy (in days): ☐ up to 30 ☐ 60 ☐ 90 ☐ 120 ☐ 180 ☐ 365 ☐Other:_____

Clinical Information

Medical History:

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 provider clnicial 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:

_____

_____

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