NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

WellCare
Beyond Healthcare. A Better You.

NC DHB Pharmacy Request for Prior Approval - Topical Anti-Inflammatory Medications

Recipient Information **DMA-0030 (v.03)**

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

9a. Drug Name: ☐ Elidel ☐ Protopic 0.03% ☐ Protopic 0.1% 9b. Is this request for a Non-Preferred Drug? ☐ Yes ☐ No
11. Quantity Per 30 Days: ____________
12. Length of Therapy (in days): ☐ up to 30 ☐ 60 ☐ 90 ☐ 120 ☐ 180 ☐ 365 ☐Other:_______

Clinical Information

For Coverage of Elidel

1. For areas OTHER than groin or face: Has the patient failed 2 generic topical corticosteroids in the highest potency class and is the patient greater than 2 years of age? ☐ Yes ☐ No
2. For groin and face: Has the patient failed 2 topical generic corticosteroids from preferred list in any potency class (see criteria for list) AND is patient greater than 2 years of age? ☐ Yes ☐ No
3. Does the patient have a documented adverse reaction or contraindication that precludes trial of 2 generic topical corticosteroids from preferred list (see criteria for list)? ☐ Yes ☐ No

Please list: ____

For Coverage of Protopic 0.03%:

4. Has the recipient tried and failed Elidel? ☐ Yes ☐ No
5. For areas OTHER than groin or face: Has the patient failed 2 generic topical corticosteroids in the highest potency class and is the patient greater than 2 years of age? ☐ Yes ☐ No
6. For groin and face: Has the patient failed 2 topical generic corticosteroids from preferred list in any potency class (see criteria for list) AND is patient greater than 2 years of age? ☐ Yes ☐ No
7. Does the patient have a documented adverse reaction or contraindication that precludes trial of 2 generic topical corticosteroids from preferred list (see criteria for list)? ☐ Yes ☐ No

Please list: ____

For Coverage of Protopic 0.1%

8. Has the recipient tried and failed Elidel? ☐ Yes ☐ No
9. For areas OTHER than groin or face: Has the patient failed 2 generic topical corticosteroids in the highest potency class and is the patient greater than 18 years of age? ☐ Yes ☐ No
10. For groin and face: Has the patient failed 2 topical generic corticosteroids from preferred list in any potency class (see criteria for list) AND is patient greater than 18 years of age? ☐ Yes ☐ No
11. Does the patient have a documented adverse reaction or contraindication that precludes trial of 2 generic topical corticosteroids from preferred list (see criteria for list)? ☐ Yes ☐ No

Please list: ____

Signature of Prescriber:____ Date:_________________

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**