WellCare
Beyond Healthcare. A Better You.

NC Medicaid and NC Health Choice
Pharmacy Prior Approval Request for Stromectol tablets (Ivermectin)

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 _____ (Max of 10) 11. Length of Therapy (in days): ☐ up to 30 Days

Clinical Information

1. Is the beneficiary being treated for a parasitic infection? ☐ **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.

Please fax this form to **1-800-678-3189** Pharmacy PA Call Center: **1-866-799-5318**