WellCare
Beyond Healthcare. A Better You.

NC Medicaid and NC Health Choice
Pharmacy Prior Approval Request for Topical Antihistamines

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 10 days

Clinical Information

Treatment for Atopic Dermatitis:

1. Has the beneficiary received previous treatment with at least one other topical antihistamine? ☐ **Yes** ☐ **No**
2. Has the beneficiary received previous treatment with at least two topical steroid creams? ☐ **Yes** ☐ **No**
3. Will the quantity be limited to 45 grams per 90 days? ☐ **Yes** ☐ **No**
4. Is this an initial authorization? Select 'Yes' for an initial authorization. Select 'No' for a reauthorization request.
   ☐ **Yes** ☐ **No** If answered no, please answer questions 4a and 4b
   4a. Have at least 3 months elapsed since the last time the beneficiary used the requested product? ☐ **Yes** ☐ **No**
   4b. Has the beneficiary benefited from therapy but remains at high risk? ☐ **Yes** ☐ **No** ** Please provide documentation that indicates the beneficiary has benefited from therapy but remains at high risk**

Treatment for Lichen Simplex Chronicus:

5. Has the beneficiary received previous treatment with at least two topical steroid creams? ☐ **Yes** ☐ **No**
6. Is this an initial authorization? Select 'Yes' for an initial authorization. Select 'No' for a reauthorization request.
   ☐ **Yes** ☐ **No** If answered no, please answer questions 6a and 6b
   6a. Have at least 3 months elapsed since the last time the beneficiary used the requested product? ☐ **Yes** ☐ **No**
   6b. Has the beneficiary benefited from therapy but remains at high risk? ☐ **Yes** ☐ **No** ** Please provide documentation that indicates the beneficiary has benefited from therapy but remains at high risk**

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 **1-800-678-3189.** Pharmacy PA Call Center: **1-866-799-5318**

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