



**NC Medicaid and NC Health Choice  
Pharmacy Prior Approval Request for  
Topical Local Anesthetics**

**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 30 days  60 Days  90 Days  120 Days  180 Days  365 Days  Other \_\_\_\_\_

**Clinical Information**

1. Is the beneficiary diagnosed with post-herpetic neuralgia?  **Yes**  **No**
2. Does the beneficiary have a diagnosis of Neuropathic pain?  **Yes**  **No** **If YES, please answer 2a**  
2a. Does the recipient have a documented trial and failure of at least two of the following drug categories: tri-cyclic antidepressant, SSRIs, SNRIs, anticonvulsants, NSAIDs, or COXIIIs or have a documented clinical reason that these products cannot be tried?  **Yes**  **No**  
Please List: \_\_\_\_\_
3. Does the beneficiary have a diagnosis of Chronic musculo-skeletal pain for greater than 6 months duration?  **Yes**  **No** **If yes, please answer 3a**  
3a. Does the recipient have a documented trial and failure of at least two of the following drug categories: tri-cyclic antidepressant, SSRIs, SNRIs, anticonvulsants, NSAIDs, or COXIIIs or have a documented clinical reason that these products cannot be tried?  **Yes**  **No**  
Please List: \_\_\_\_\_

**For Non-preferred medication requests:**

4. Has the beneficiary tried and failed a preferred neuropathic pain medication?  **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.

Fax this form to (800) 678-3189

Pharmacy PA Call Center: (866) 799-5318