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:

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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:

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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:

____

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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**