carolina complete health

Pharmacy Request for Prior Approval
Non-Steroidal Anti-Inflammatory Drugs including Cox-2 Inhibitors

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: _____ 10. Strength:_____ 11. Quantity Per 30 Days: _____
12. Length of Therapy (in days): ☐ up to 30 ☐ 60 ☐ 90 ☐ 120 ☐ 180 ☐ Other:_____

Clinical Information

1. Is the patient being treated for pain (acute of chronic)? ☐ Yes ☐ No
2. Does the patient have a documented history of GI Bleed, Gastric Ulcer, or Duodenal Ulcer? ☐ Yes ☐ No
3. Is the patient receiving a systemic (oral or parenteral) corticosteroid? ☐ Yes ☐ No
4. Does the patient have a history of Platelet Dysfunction of Coagulopathy? ☐ Yes ☐ No
5. Does the patient have a diagnosis of Familial Adenomatous Polyposis (FAP)? ☐ Yes ☐ No
6. Does the patient have a previous intolerance to at least 2 non-COX 2 classes of NSAIDs at therapeutic doses? ☐ Yes ☐ No

If requesting a non-preferred medication, answer question #7

7. Has the patient tried and failed on a preferred medication? Yes ☐ No ☐
   Please list preferred tried_____

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: (877) 386-4695 Pharmacy PA Call Center: (833) 585-4309