carolina complete health

Prior Approval Request for Epinephrine Pens

Beneficiary Information

1. Beneficiary Last Name:_____ 2. First Name: _____
3. Beneficiary ID #:_____ 4. Beneficiary Date of Birth:_____ 5. Beneficiary Gender: _____

Prescriber Information

7. Prescribing Provider NPI #: _____
8. Requester Contact Information
   Name:_____ Phone #:_____ Ext. _____

Drug Information

9. Drug Name: _____ 10. Strength:_____ 11. Quantity Per 30 Days: _____
12. Length of Therapy (days): ☐ up to 30 ☐ 60 ☐ 90 ☐ 120 ☐ 180 ☐ 365 ☐ Other: _____

Clinical Information

Preferred Products:

1. Is the requested quantity for more than 6 pens per 180 days? ☐ Yes ☐ No
2. Prescriber, please submit reasoning for medical necessity of the quantity limit exceeding the allowable maximum of 6 pens per 180 days.

_____
_____
_____
_____

Non-Preferred Products:

1. Is the requested quantity for more than 6 pens per 180 days? ☐ Yes ☐ No
2. Prescriber, please submit reasoning for medical necessity of the quantity limit exceeding the allowable maximum of 6 pens per 180 days.

_____
_____
_____
_____

☐ Failed two preferred drug(s). If only one preferred drug is available, then failed one preferred drug.

List preferred drugs failed: _____

☐ Allergic Reaction

☐ Drug-to-drug interaction. *Please describe reaction*: _____

☐ Previous episode of an unacceptable side effect or therapeutic failure.

Please provide clinical information: _____

☐ Clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to preferred drug(s).

Please provide clinical information: _____

☐ Age specific indications. *Please give patient age and explain:* _____

☐ Unique clinical indication supported by FDA approval or peer reviewed literature. *Please explain and provide a general reference*: _____

☐ Unacceptable clinical risk associated with therapeutic change. *Please explain:* _____

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