carolina complete health

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

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

Drug Information

9. Drug Name: _____ 10. Strength:_____ 11. Quantity Per 10 Days: _____
12. Length of Therapy (days): ☐ 10 days ☐ Other: _____

Clinical Information

Atopic Dermatitis

1. Has the beneficiary received previous treatment with at least one other topical antihistamine? ☐ Yes ☐ No
   Please list other antihistamine tried_____
2. Has the beneficiary received previous treatment with at least two topical steroid creams? ☐ Yes ☐ No
   Please list other topical steroid creams tried_____
3. Is this request for a continuation of therapy? ☐ Yes ☐ No **(must also answer questions 1 and 2 on continuation requests)**
   3a. **(For continuation requests)** Has documentation been attached to this request that indicates the beneficiary has benefited from therapy but remains at high risk? ☐ Yes ☐ No

Lichen Simplex Chronicus

1. Has the beneficiary received previous treatment with at least two topical steroid creams? ☐ Yes ☐ No
   Please list other topical steroid creams tried_____
2. Is this request for a continuation of therapy? ☐ Yes ☐ No **(must also answer question 1 on continuation requests)**
   2a. **(For continuation requests)** Has documentation been attached to this request that indicates the beneficiary has benefited from therapy but remains at high risk? ☐ Yes ☐ No

****Coverage limited to no more than 45 grams per 90 days**

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