carolina complete health

Pharmacy Prior Approval Request for Epinephrine Products

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

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 six (6) pens. _____

Non-Preferred Products:

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: _____
3. ☐ Clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to preferred drug(s). Please provide clinical information: _____
4. ☐ Age specific indications. Please give patient age and explain: _____
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: _____
7. Is the requested quantity for more than 6 pens per 180 days? ☐ **Yes** ☐ **No**
8. Prescriber please submit reasoning for medical necessity of the quantity limit exceeding the allowable maximum of six (6) pens. _____

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: (833) 404-2393 Pharmacy PA Call Center: (833) 585-4309

https://www.covermymeds.com/main/prior-authorization-forms/