



## Pharmacy Prior Approval Request for Stromectol (ivermectin) Tablets

### 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 \_\_\_\_\_ (Max of 10) 11. Length of Therapy (in days):  up to 30 Days

### Clinical Information

1. Is the beneficiary being treated for a parasitic infection?  Yes  No

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.