

NC Medicaid and NC Health Choice
Pharmacy Prior Approval Request for
Topical Local Anesthetics

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

1. Is the beneficiary diagnosed with post-herpetic neuralgia? **Yes** **No**
2. Does the beneficiary have a diagnosis of Neuropathic pain? **Yes** **No** **If YES, please answer 2a**
- 2a. Does the recipient have a documented trial and failure of at least two of the following drug categories: tri-cyclic antidepressant, SSRIs, SNRIs, anticonvulsants, NSAIDs, or COXIIIs or have a documented clinical reason that these products cannot be tried? **Yes** **No**
Please List: _____
3. Does the beneficiary have a diagnosis of Chronic musculo-skeletal pain for greater than 6 months duration? **Yes** **No** **If yes, please answer 3a**
- 3a. Does the recipient have a documented trial and failure of at least two of the following drug categories: tri-cyclic antidepressant, SSRIs, SNRIs, anticonvulsants, NSAIDs, or COXIIIs or have a documented clinical reason that these products cannot be tried? **Yes** **No**
Please List: _____

For Non-preferred medication requests:

4. Has the beneficiary tried and failed a preferred neuropathic pain medication? **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.