SANDHILLS CENTER

Pharmacy Request for Prior Approval – Topical Antihistamines

Beneficiary Information

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

Prescriber Information

6. Prescriber Name: _____ NPI #: _____
Mailing address: _____ City: _____ State: _____ ZIP: _____
7. Requester Contact Information: _____
Name: _____ Phone #: _____ Fax #: _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy: ___up to 10 days

Clinical Information

Treatment of Atopic Dermatitis:

1. Has the beneficiary received previous treatment with at least one other topical antihistamine? Yes___ No___
2. Has the beneficiary received previous treatment with at least two topical steroid creams? Yes___ No___
3. Will the quantity be limited to 45 grams per 90 days? Yes___ No___
4. Is this an initial authorization? Select 'Yes' for an initial authorization. Select 'No' for a reauthorization request.
Yes___ No___ If answered no, please answer questions 4a and 4b.
   4a. Have at least 3 months elapsed since the last time the beneficiary used the requested product? Yes___ No___
   4b. Has the beneficiary benefited from therapy but remains at high risk? Yes___ No___
   **** Please provide documentation that indicates the beneficiary has benefited from therapy but remains at high risk****

Treatment for Lichen Simplex Chronicus:

5. Has the beneficiary received previous treatment with at least two topical steroid creams? Yes___ No___
6. Is this an initial authorization? Select 'Yes' for an initial authorization. Select 'No' for a reauthorization request.
Yes___ No___ If answered no, please answer questions 6a and 6b.
   6a. Have at least 3 months elapsed since the last time the beneficiary used the requested product? Yes___ No___
   6b. Has the beneficiary benefited from therapy but remains at high risk? Yes___ No___
   **** Please provide documentation that indicates the beneficiary has benefited from therapy but remains at high risk****

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 to: 1-833-727-3741 or Call PerformRx for help: 1-888-846-1062