UnitedHealthcare Community Plan

NC 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 #: _____ Provider Fax#: _____
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 patient diagnosed with post-herpetic neuralgia? ☐ **Yes** ☐ **No**
2. Does the recipient 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 COXIIs? ☐ **Yes** ☐ **No**
   Please List: _____

3. Does the recipient have a diagnosis of Chronic musculo-skeletal pain for greater than 6 months duration? ☐ **Yes** ☐ **No If yes, please answer 2a**
   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 COXIIs? ☐ **Yes** ☐ **No**
   Please List**:** _____
   _____.

For Continuation: (answer in addition to the questions above)
Has the beneficiary shown continued benefit and improvement or stability in functional status? ☐ **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.

Fax this form to 1-866-940-7328

Pharmacy PA Call Center: 1-855-258-1593