



**NC DMA Pharmacy Request for Prior Approval -
Standard Drug Request Form**



Recipient Information

DMA-3106 (V.01)

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

Payer Information

6. Is this a Medicaid or Health Choice Request? Medicaid: Health Choice:

Prescriber Information

7. Prescribing Provider #: _____ NPI: or Atypical:

8. Prescriber DEA #: _____

Requester Contact Information

Name: _____ Phone #: _____ Ext: _____

Drug Information

9. Drug Name: _____ 9b. Is this request for a Non-Preferred Drug? Yes No
10. Strength: _____ 11. Quantity Per 30 Days: _____
12. Length of Therapy (in days): up to 30 60 90 120 180 365 Other: _____

Clinical Information

Medical History:

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: _____

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 CSRA at: (855) 710-1969

Pharmacy PA Call Center: (866) 246-8505