



NC DMA Pharmacy Request for Prior Approval Narcotic Analgesic



Recipient Information

DMA-0015 (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

9a. 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

****If the requested daily dose is greater than or equal to 750mg of morphine or an equivalent dose, the request will be denied.**

1. Does the patient have a diagnosis of malignant cancer or pain due to neoplasm? Yes No If yes, the patient is exempt from the prior authorization requirement

2. Has the prescriber reviewed and is adhering to the N.C. Medical Board statement on the use of controlled substances for the treatment of pain? Yes No

Criteria for Use of Short-Acting Narcotic Analgesics:

Preferred Products:

3. Is the requested daily dose less than or equal to 750mg of morphine or an equivalent dose? Yes No

Non-Preferred Products:

4. Is the requested daily dose less than or equal to 750mg of morphine or an equivalent dose? Yes No

5. Does the patient have a documented history within the past year of a 30 day trial of a preferred short-acting Narcotic Analgesic at a dose equal to or equivalent to the non-preferred short acting Narcotic Analgesic being prescribed? Yes No

Please list: _____

6. Does the patient have a contraindication or allergy to ingredients in the preferred product? Yes No

Please list: _____

Criteria for Use of Long-Acting Narcotic Analgesics:

Preferred Products:

7. Does the patient have a diagnosis of chronic pain syndrome of at least 4 weeks duration? Yes No

8. Is the requested daily dose less than or equal to 750mg of morphine or an equivalent dose? Yes No

Non-Preferred Products:

9. Does the patient have a diagnosis of chronic pain syndrome of at least 4 weeks duration? Yes No

10. Is the requested daily dose less than or equal to 750mg of morphine or an equivalent dose? Yes No

11. Does the patient have a documented history within the past year of a 30-day trial of a preferred long-acting Narcotic Analgesic at a dose equal to or equivalent to the non-preferred long acting Narcotic Analgesic being prescribed? Yes No

Please list: _____

12. Does the patient have a contraindication or allergy to ingredients in the preferred product? Yes No

Please list: _____

Signature of Prescriber: _____ Date: _____

*Prescriber signature mandatory

Fax this form to CSC at: (855) 710-1969

Pharmacy PA Call Center: (866) 246-8505