

ANTIFUNGALS, ORAL PRIOR AUTHORIZATION FORM

To review the prior authorization guidelines for Oral Antifungals, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – **Antifungals, Oral** (accessible at:

<http://www.dhs.pa.gov/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm>).

PRIOR AUTHORIZATION REQUEST INFORMATION			PRESCRIBER INFORMATION		
<input type="checkbox"/> New request	<input type="checkbox"/> Additional info (PA#: _____)	# of pages in request: _____	Prescriber name:		
<input type="checkbox"/> Renewal request					
Name of office contact:			Specialty:		
Contact's phone number:			State license #:		
LTC facility contact/phone:			NPI:	MA Provider ID#:	
RECIPIENT INFORMATION			Street address:		
Recipient Name:			Suite #:	City/state/zip:	
Recipient ID#:	DOB:	Phone:	Fax:		

CLINICAL INFORMATION

Non-preferred medication requested					
<input type="checkbox"/> Ancobon capsule	<input type="checkbox"/> griseofulvin microsize tablet	<input type="checkbox"/> nystatin powder (for compounding)	<input type="checkbox"/> Sporanox capsule		
<input type="checkbox"/> Cresemba capsule	<input type="checkbox"/> Gris-PEG tablet	<input type="checkbox"/> Noxafil DR tablet	<input type="checkbox"/> Sporanox solution		
<input type="checkbox"/> Diflucan tablet	<input type="checkbox"/> itraconazole capsule	<input type="checkbox"/> Noxafil suspension	<input type="checkbox"/> VFEND tablet		
<input type="checkbox"/> Diflucan suspension	<input type="checkbox"/> ketoconazole tablet	<input type="checkbox"/> Onmel tablet	<input type="checkbox"/> VFEND suspension		
<input type="checkbox"/> flucytosine capsule	<input type="checkbox"/> Lamisil tablet	<input type="checkbox"/> Oravig buccal tablet	<input type="checkbox"/> voriconazole tablet		
<input type="checkbox"/> Grifulvin-V tablet	<input type="checkbox"/> Lamisil granules for suspension		<input type="checkbox"/> voriconazole suspension		
Directions:			Quantity:	Refills:	
Diagnosis (<i>submit documentation</i>):			DX code (<i>required</i>):		
1. Has the Recipient tried and failed any of the preferred Oral Antifungals? <i>Check all that apply.</i>			<input type="checkbox"/> Yes – <i>submit all supporting documentation of drug regimen and therapeutic failure</i> <input type="checkbox"/> No		
<input type="checkbox"/> clotrimazole troche	<input type="checkbox"/> griseofulvin ultramicrosize tablet	<input type="checkbox"/> nystatin tablet or suspension			
<input type="checkbox"/> fluconazole tablet or suspension	<input type="checkbox"/> nystatin tablet or suspension	<input type="checkbox"/> terbinafine tablet	<input type="checkbox"/> Yes – <i>submit all supporting documentation of medication name(s) and associated intolerances and contraindications</i> <input type="checkbox"/> No		
<input type="checkbox"/> griseofulvin microsize suspension	<input type="checkbox"/> terbinafine tablet				
2. Does the Recipient have any contraindications or intolerances to any of the preferred agents listed in question (1)?			<input type="checkbox"/> Yes – <i>submit documentation of diagnosis and planned duration of treatment</i> <input type="checkbox"/> No		
3. Does the Recipient have a diagnosis for which none of the preferred Oral Antifungals are indicated or widely medically-accepted? <i>Check all that apply or indicate diagnosis.</i>					
<input type="checkbox"/> aspergillosis	<input type="checkbox"/> mucormycosis				
<input type="checkbox"/> blastomycosis	<input type="checkbox"/> other (specify): _____				
<input type="checkbox"/> histoplasmosis	_____				

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	Date:
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