



Request for Prior Authorization
ANTIFUNGAL DRUGS- ORAL / INJECTABLE

(PLEASE PRINT - ACCURACY IS IMPORTANT)

Form with fields for IA Medicaid Member ID #, Patient name, DOB, Patient address, Provider NPI, Prescriber name, Phone, Prescriber address, Fax, Pharmacy name, Address, Phone, Pharmacy NPI, Pharmacy fax, NDC.

Prior authorization is not required for preferred antifungal therapy for a cumulative 90 days of therapy per 12-month period per patient. Prior authorization is required for all non-preferred antifungal therapy as indicated on the Iowa Medicaid Preferred Drug List beginning the first day of therapy.

Preferred (PA required after 90 days)

- Clotrimazole Troche
Fluconazole
Griseofulvin Suspension
Terbinafine
Voriconazole
Other:

Non-Preferred (PA required from Day 1)

- Cresemba
Diflucan
Grifulvin V
Gris-Peg
Griseofulvin Tablets
Itraconazole
Ketoconazole Tablets
Lamisil
Noxafil
Onmel
Oravig
Sporanox
Tolsura
Vfend
Other:

Strength

Dosage Instructions

Quantity

Days Supply

Diagnosis:

Does the patient have an immunocompromised condition? Yes No

If yes, diagnosis:

Does the patient have a systemic fungal infection? Yes No

If yes, date of diagnosis: Type of infection:

Previous trial(s) with preferred drug(s): Drug Name Strength

Trial Date from Trial Date to:

Medical or contraindication reason to override trial requirements:

Reason for use of Non-Preferred drug requiring prior approval:

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.) Date of submission

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid.