Iowa Medicaid
IOWA HHS

Request for Prior Authorization

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

ANTIFUNGAL DRUGS- ORAL / INJECTABLE

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone

Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.

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. Payment for a non-preferred antifungal will be authorized only for cases in which there is documentation of previous trial(s) and therapy failure with a preferred agent(s). Payment for any antifungal therapy beyond this limit will be authorized in cases where the patient has a diagnosis of an immunocompromised condition or a systemic fungal infection. This prior authorization requirement does not apply to nystatin.

Preferred (PA required after 90 days)

- ☐ Caspofungin
- ☐ Clotrimazole Troche
- ☐ Fluconazole
- ☐ Griseofulvin Suspension
- ☐ Micafungin
- ☐ Terbinafine
- ☐ Vfend Oral Suspension
- ☐ Voriconazole IV
- ☐ Other: _____

Non-Preferred (PA required from Day 1)

- ☐ Ancobon
- ☐ Cancidas
- ☐ Cresemba
- ☐ Diflucan
- ☐ Griseofulvin Tablets
- ☐ Itraconazole
- ☐ Ketoconazole Tablets
- ☐ Noxafil
- ☐ Posaconazole
- ☐ Sporanox
- ☐ Tolsura
- ☐ Voriconazole Oral Susp
- ☐ Vfend IV
- ☐ Vivjoa
- ☐ 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. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.*

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