# *Antifungal Drugs — Oral/Injectable*
# *Prior Authorization of Benefits Form*

**CONTAINS CONFIDENTIAL PATIENT INFORMATION**
**Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 1-844-512-9004.**
**Provider Help Desk: 1-800-454-3730**

| **1. Patient information** | **2. Physician information** |
|---|---|
| Patient name: _____ | Prescribing physician: _____ |
| Patient ID #: _____ | Physician address: _____ |
| Patient DOB: _____ | Physician phone #: _____ |
| Date of Rx: _____ | Physician fax #: _____ |
| Patient phone #: _____ | Physician specialty: _____ |
| Patient email address: _____ | Physician DEA: _____ |
| | Physician NPI #: _____ |
| | Physician email address: _____ |

| **3. Medication** | **4. Strength** | **5. Directions** | **6. Quantity per 30 days** |
|---|---|---|---|
| _____ | _____ | _____ | Specify: _____ |

**7. Diagnosis:** _____

**8. Approval criteria:** (Check all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.)

Prior authorization (PA) 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)**
- ☐ Clotrimazole Troche
- ☐ Fluconazole
- ☐ Griseofulvin Suspension
- ☐ Terbinafine
- ☐ Voriconazole
- ☐ Other: _____

**Nonpreferred (PA required from day 1)**
- ☐ Cresemba
- ☐ Diflucan
- ☐ Grifulvin V
- ☐ Gris-Peg
- ☐ Griseofulvin tablets
- ☐ Itraconazole
- ☐ Ketoconazole tablets
- ☐ Lamisil
- ☐ Noxafil
- ☐ Onmel
- ☐ Oravig
- ☐ Posaconazole
- ☐ Sporonox
- ☐ Tolsura
- ☐ Vfend
- ☐ Other_____

Does the patient have an immunocompromised condition? ☐ Yes ☐ No

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 nonpreferred drug requiring prior approval:

_____

_____

***Attach lab results and other documentation as necessary.***

**9. Physician signature**

_____ _____

Prescriber or authorized signature Date

*Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.*

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.