

ANTIVIRALS, TOPICAL PRIOR AUTHORIZATION FORM

- Please submit all requested documentation with this request. Incomplete documentation may delay the processing of this request.
- To review the prior authorization guidelines for Topical Antivirals, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – **Antivirals, Topical** (accessible at: <http://www.dhs.pa.gov/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm>).

| PRIOR AUTHORIZATION INFORMATION | | | PRESCRIBER INFORMATION | |
|--------------------------------------|---|---------------------------------|------------------------|------------------|
| <input type="checkbox"/> New request | <input type="checkbox"/> Additional info (PA# _____) | # of pages in request: _____ | Prescriber name: | |
| 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"/> acyclovir 5% ointment <input type="checkbox"/> Xerese cream <input type="checkbox"/> Zovirax 5% ointment | | |
| Directions: | Quantity: | Refills: |
| Diagnosis (<i>submit documentation</i>): | Dx code (<i>required</i>): | |
| 1. Does the Recipient have a history of trial and failure, contraindication, or intolerance of the preferred Topical Antivirals? <i>Check all that apply.</i> <input type="checkbox"/> Abreva 10% OTC cream <input type="checkbox"/> Denavir 1% cream <input type="checkbox"/> Zovirax 5% cream | <input type="checkbox"/> Yes – <u>submit all supporting documentation of preferred agents tried and treatment outcomes, including contraindications or intolerances</u> <input type="checkbox"/> No | |

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

| | |
|-----------------------|-------|
| Prescriber Signature: | Date: |
|-----------------------|-------|

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