

IMMUNOMODULATORS, 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 Immunomodulators, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – **Immunomodulators, 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"/> imiquimod 5% cream packet <input type="checkbox"/> Zyclara 3.75% cream	<input type="checkbox"/> Zyclara 2.5% cream <u>pump</u> <input type="checkbox"/> Zyclara 3.75% cream <u>pump</u>
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 Immunomodulators agent, <u>Aldara 5% cream</u> ?		<input type="checkbox"/> Yes – <u>submit all supporting documentation of preferred agent tried and treatment outcome, 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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