pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

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**	
☐New request ☐Renewal request	Total # of pages: _____	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:	☐Aldara 5% cream packet ☐Zyclara 3.75% cream packet	☐Zyclara 2.5% cream pump ☐Zyclara 3.75% cream pump
Directions:	Quantity:	Refills:
Diagnosis *(submit documentation)*:	Dx code (*required*):	
1. Does the Recipient have a history of trial and failure, contraindication, or intolerance of the preferred Topical Immunomodulators agent, **imiquimod 5% cream?**	☐Yes – *submit all supporting documentation of preferred agent tried and treatment outcome, including contraindications or intolerances.* ☐No	

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

Prescriber Signature:	**Date**: