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

ANTIFUNGALS, ORAL PRIOR AUTHORIZATION FORM

To review the prior authorization guidelines for Oral Antifungals, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapters – **Antifungals, Oral** and **Quantity Limits/Daily Dose Limits** (accessible at: http://www.dhs.pa.gov/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm).

PRIOR AUTHORIZATION REQUEST 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

☐Ancobon capsule	☐griseofulvin microsize tablet	☐Noxafil DR tablet	☐Sporanox solution
☐Cresemba capsule	☐Gris-PEG tablet	☐Noxafil suspension	☐VFEND tablet
☐Diflucan tablet	☐itraconazole capsule	☐Onmel tablet	☐VFEND suspension
☐Diflucan suspension	☐ketoconazole tablet	☐Oravig buccal tablet	☐voriconazole tablet
☐flucytosine capsule	☐Lamisil tablet	☐Sporanox capsule	☐voriconazole suspension

Directions:	Quantity:	Refills:
Diagnosis *(submit documentation)*:	Dx code (*required*):	

1. Has the Recipient tried and failed any of the preferred Oral Antifungals? *Check all that apply.* ☐clotrimazole troche ☐griseofulvin ultramicrosize tablet ☐fluconazole tablet or suspension ☐nystatin tablet or suspension ☐griseofulvin microsize suspension ☐terbinafine tablet	☐Yes – *Submit all supporting documentation of drug regimen and therapeutic failure*. ☐No
2. Does the Recipient have any contraindications or intolerances to any of the preferred agents listed in question (1)?	☐Yes – *Submit all supporting documentation of medication name(s) and associated intolerances and contraindications*. ☐No
3. Does the Recipient have a diagnosis for which none of the preferred Oral Antifungals are indicated or widely medically-accepted? *Check all that apply or indicate diagnosis.* ☐aspergillosis ☐mucormycosis ☐blastomycosis ☐other (specify): _____ ☐histoplasmosis _____	☐Yes – *Submit documentation of diagnosis and planned duration of treatment*. ☐No

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

Prescriber Signature:	**Date**: