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, TOPICAL PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Antifungals, Topical** are 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#:
BENEFICIARY INFORMATION		Street address:	
Beneficiary name:		Suite #:	City/State/Zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Non-preferred medication requested

☐Alevazol OTC ointment
☐Bensal HP ointment
☐butenafine cream
☐Ciclodan 0.77% cream
☐Ciclodan 0.77% cream kit
☐Ciclodan nail lacquer solution
☐Ciclodan Kit nail lacquer solution
☐ciclopirox 0.77% cream
☐ciclopirox 0.77% gel
☐ciclopirox 0.77% suspension
☐ciclopirox 1% shampoo
☐ciclopirox 8% nail solution
☐clotrimazole 1% Rx cream
☐clotrimazole 1% Rx solution
☐clotrimazole/betamethasone lotion
☐econazole 1% cream
☐Ertaczo 2% cream
☐Exelderm 1% cream
☐Exelderm 1% solution
☐Extina 2% foam
☐Fungoid OTC tincture
☐Fungoid OTC tincture nail kit
☐Jublia solution
☐Kerydin solution
☐ketoconazole foam
☐Loprox 0.77% cream
☐Loprox 0.77% cream kit
☐Loprox shampoo
☐Loprox 0.77% suspension
☐Loprox 0.77% suspension kit
☐Lotrisone cream
☐Luzu 1% cream
☐Mentax 1% cream
☐naftifine 1% cream
☐naftifine 2% cream
☐Naftin 2% cream
☐Naftin 1% gel
☐Naftin 2% gel
☐Nizoral 2% Rx shampoo
☐nystatin/triamcinolone cream
☐nystatin/triamcinolone ointment
☐Nystop powder
☐oxiconazole cream
☐Oxistat 1% cream
☐Oxistat 1% lotion
☐Penlac nail lacquer solution
☐Vusion ointment
☐______________________

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

Complete section applicable to the requested medication.

Section A: Requests for nail lacquer/solution for the treatment of onychomycosis

1. Does the Beneficiary have onychomycosis as confirmed by results of a fungal culture of the affected nail(s)?
   ☐Yes – *Submit documentation of diagnosis and culture results.*
   ☐No – *Submit medical literature supporting the use of the requested agent for the Beneficiary's indication.*

2. Does the Beneficiary have a medical, non-cosmetic indication that necessitates treatment of the affected nail(s)? *Check all that apply.*
   ☐affected nails cause pain or discomfort
   ☐comorbidity increasing risk of complications (ex. diabetes)
   ☐peripheral artery diseases (PAD)
   ☐history of recurrent bacterial infections around the affected nail(s)
   ☐other *(specify)*: __________________
   ☐Yes ☐No — *Submit documentation supporting the medical (non-cosmetic) necessity of the requested agent.*

3. Does the Beneficiary have a history of trial and failure, contraindication, or intolerance to ORAL antifungal agents for the treatment of onychomycosis? *Check all that apply.*
   ☐itraconazole capsule* *(Sporanox)* (*non-preferred, requires prior authorization)
   ☐terbinafine tablet *(Lamisil)*
   ☐Yes – *Submit all supporting documentation of medication name(s) and associated trial and failure, intolerance, and contraindications.*
   ☐No

Section B: All other non-preferred requests

1. Does the Beneficiary have a history of trial and failure (within the past year), contraindication, or intolerance to the following preferred medications? *Check all that apply and submit all supporting documentation of medication name(s) and associated trial and failure, intolerance, and contraindications*
   ☐clotrimazole 1% OTC cream or solution
   ☐clotrimazole/betamethasone Rx cream
   ☐ketoconazole 2% Rx cream or shampoo
   ☐miconazole 2% OTC cream, powder, spray (eg, Desenex, Zeasorb)
   ☐nystatin 100,000 units/gm Rx cream, ointment, powder
   ☐terbinafine 1% OTC cream, gel, spray (eg, Lamisil AF Defense, Lamisil AT)
   ☐tolnaftate 1% OTC cream, powder, spray

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

Prescriber Signature:	Date:

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