



Prior Authorization Request Form – Topical Anti-fungal Medications

Instructions:

This form is to be used by participating providers to request coverage for topical anti-fungal medications requiring prior authorization. Please fill out this form COMPLETELY, including signature, and fax to MedMetrics Health Partners at 1-800-918-7542. Allow 24 hours to process request. Please call MedMetrics PA Line (available 24 hours a day) at 1-800-918-7550 for more urgent requests.

MedMetrics Health Partners – Prior Authorization Services
 P. O. Box 2586, Worcester, MA 01606

Phone: 1-800-918-7550
 Fax: 1-800-918-7542

A topical anti-fungal step therapy program has been developed to encourage the use of first-line therapies before second-line therapies are used for the same indication.

First-line therapies include: ciclopirox, clotrimazole, clotrimazole/betamethasone, econazole, ketoconazole, miconazole, nystatin, nystatin/triamcinolone, and tolnaftate.

Please PRINT and complete ALL of the following boxes:

1. Member's FULL Name:	2. Member's NHP ID Number:	3. Member's DOB: (mm/dd/yy)
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4. Prescriber's FULL Name <u>and Specialty</u> : Mailing Address:	5. Contact Person at Office:
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Prescriber's FAX and Telephone Number:	Fax: ()	Tel: ()
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7. Requested Drug: <input type="checkbox"/> Ertaczo 2% cream <input type="checkbox"/> Exelderm 1%, ___ cream, ___ solution <input type="checkbox"/> Halotin 1% cream <input type="checkbox"/> Mentax 1% cream <input type="checkbox"/> Naftin 1%, ___ cream, ___ gel <input type="checkbox"/> Oxistat 1%, ___ cream, ___ lotion <input type="checkbox"/> Xolegel 2% gel <input type="checkbox"/> Other: _____	8. Other Pertinent Information: <hr/> <hr/> <hr/>
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9. Has the member tried at least four of the following generic products within the past 180 days?

Drug Name (please check all that apply)	Response (please check all that apply)
<input type="checkbox"/> ciclopirox	<input type="checkbox"/> side-effect <input type="checkbox"/> non-response <input type="checkbox"/> allergy
<input type="checkbox"/> clotrimazole	<input type="checkbox"/> side-effect <input type="checkbox"/> non-response <input type="checkbox"/> allergy
<input type="checkbox"/> clotrimazole/betamethasone	<input type="checkbox"/> side-effect <input type="checkbox"/> non-response <input type="checkbox"/> allergy
<input type="checkbox"/> econazole	<input type="checkbox"/> side-effect <input type="checkbox"/> non-response <input type="checkbox"/> allergy
<input type="checkbox"/> ketoconazole	<input type="checkbox"/> side-effect <input type="checkbox"/> non-response <input type="checkbox"/> allergy
<input type="checkbox"/> miconazole	<input type="checkbox"/> side-effect <input type="checkbox"/> non-response <input type="checkbox"/> allergy
<input type="checkbox"/> nystatin	<input type="checkbox"/> side-effect <input type="checkbox"/> non-response <input type="checkbox"/> allergy
<input type="checkbox"/> nystatin/triamcinolone	<input type="checkbox"/> side-effect <input type="checkbox"/> non-response <input type="checkbox"/> allergy
<input type="checkbox"/> tolnaftate	<input type="checkbox"/> side-effect <input type="checkbox"/> non-response <input type="checkbox"/> allergy

10. Prescriber comments:

Signature:

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

 Prescriber's signature

 Date