



## Prior Authorization Request Form – Vaginal Anti-infective Medications

**Instructions:**

This form is to be used by participating providers to request coverage for vaginal anti-infective medications. 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      Phone: 1-800-918-7550  
 P. O. Box 2586, Worcester, MA 01606                                      Fax: 1-800-918-7542

A vaginal anti-infective medication step therapy program has been developed to encourage the use of generic first-line therapies before more expensive second-line agents for the same indication.  
**First-line vaginal antifungal agents include: generic clotrimazole vaginal and generic miconazole vaginal**  
**First-line vaginal antibiotic agents include: generic clindamycin vaginal (Clindamax) and generic metronidazole vaginal (Vandazole)**

**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 & Specialty:	5. Contact Person at Office:
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6. Prescriber's FAX & Telephone Number: Fax: (      )	Tel: (      )
Mailing Address:	

7. Requested vaginal antifungal agent: <input type="checkbox"/> butoconazole (Gynazole®) <input type="checkbox"/> terconazole <input type="checkbox"/> other _____ Please include duration of treatment: _____	Requested vaginal antibiotic agent: <input type="checkbox"/> Cleocin Ovules (clindamycin suppositories) <input type="checkbox"/> other _____ Please include duration of treatment: _____
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8. Diagnosis/Indication for use:
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9. Is the member currently pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No    Please specify approximate gestational age: _____(weeks)
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10. Has the member tried the following within the past 30 days? (Please complete for vaginal antifungal request.)	
Drug Name (please check all that apply)	Response (please check all that apply)
<input type="checkbox"/> generic clotrimazole vaginal	<input type="checkbox"/> side-effect <input type="checkbox"/> non-response <input type="checkbox"/> allergy
<input type="checkbox"/> generic miconazole vaginal	<input type="checkbox"/> side-effect <input type="checkbox"/> non-response <input type="checkbox"/> allergy

Has the member tried the following within the past 30 days? (Please complete for vaginal antibiotic request.)	
Drug Name (please check all that apply)	Response (please check all that apply)
<input type="checkbox"/> generic clindamycin vaginal (Clindamax)	<input type="checkbox"/> side-effect <input type="checkbox"/> non-response <input type="checkbox"/> allergy
<input type="checkbox"/> generic metronidazole vaginal (Vandazole)	<input type="checkbox"/> side-effect <input type="checkbox"/> non-response <input type="checkbox"/> allergy

11. Prescriber comments:
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**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