



## Prior Authorization Request Form for Antifungal, Topical

**FAX this completed form to (844) 205-3386**

**OR Mail requests to: Pharmacy Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720**

**OR Prior authorization may be completed at <https://www.covermymeds.com/main/prior-authorization-forms/>**

I. PROVIDER INFORMATION		II. MEMBER INFORMATION	
Prescriber Name:		Member Name:	
Prescriber Specialty:		Identification #:	
NPI:		Group #:	
Office Contact Name:		Date of Birth:	
Fax #:		Medication Allergies:	
Phone #:			
III. DRUG INFORMATION (One drug request per form)			
Drug name and strength:		Dosage Interval (sig):	Qty. per Day:
IV. REQUIRED DOCUMENTATION (Detailed medical record documentation demonstrating evidence for each item must be submitted with prior authorization request)			
Specify diagnosis & diagnosis code relevant to this request: _____ Dx/Dx Code: _____			
<b>Requests for all non-preferred medications:</b> Does the member have a history of trial and failure of or contraindication or intolerance to the preferred Antifungal, Topical? Refer to <a href="https://papdl.com/preferred-drug-list">https://papdl.com/preferred-drug-list</a> for a list of preferred and non-preferred medications in this class.		<input type="checkbox"/> Yes	Medication Taken Previously (start and end date and dose): _____
		<input type="checkbox"/> No	_____
<input type="checkbox"/> If requesting for daily quantity exceeding daily limit (Refer to <a href="https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/Quantity-Limits-and-Daily-Dose-Limits.aspx">https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/Quantity-Limits-and-Daily-Dose-Limits.aspx</a> ), please provide supporting information: _____			
<b>SUBMIT MEDICAL RECORD INFORMATION FOR EACH APPLICABLE ITEM.</b>			
<b>RENEWAL REQUESTS:</b>			
<input type="checkbox"/> Rationale for continued use of requested medication: _____			
IV. ADDITIONAL RATIONALE FOR REQUEST / PERTINENT CLINICAL INFORMATION :			
Appropriate clinical information to support the request on the basis of medical necessity must be submitted.		Provider Signature:	Date:

Pharmacy Department will respond via fax or phone within 24 hours.

Requests for prior authorization (PA) requests must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)