

ZYCLARA™ (imiquimod cream 3.75%)

Prior Authorization Request (Physician to Complete)



Visit www.wellmark.com for the Wellmark Drug List for current medication tier levels and updated PA Forms

Facsimile Transmittal Sheet

Date: ____/____/____

To: Wellmark Pharmacy Services

From (Prescriber's Name): _____

Fax Number: (866) 884-4345

Prescriber's DEA Number: _____

Phone Number: (800) 600-8065

Prescriber's Phone Number: _____

Prescriber's Specialty: _____

Prescriber's Fax Number: _____

Prescriber's Office Address: _____
Street Suite # City State Zip

Patient Name: _____

Patient ID: _____ Patient DOB: ____/____/____

Please answer the following questions and fax this form back to (866) 884-4345. All fields are REQUIRED.

1. What is the patient's current dermatologic diagnosis? _____
ICD-9 Code: _____
2. Is the requested medication to be used on the face or scalp?
 Yes No
3. Does the patient have a diagnosis of external genital or anal warts?
 Yes No
4. Is the patient 12 years of age or older?
 Yes No
5. Has the patient had a trial of cryotherapy OR is the patient unable to use cryotherapy?
 Yes No
6. Has the patient tried Aldara or generic imiquimod cream 5%?
 Yes No
7. What is the reason that the patient cannot use or continue to use Aldara/imiquimod cream 5%?

Printed Name

Signature

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