

Anti-Fungals

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. Please provide the diagnosis this therapy has been prescribed for: _____

ICD-9 Code: _____ Fungal species: _____

2. Can the patient swallow tablets or capsules? Yes No

3. Please list all medical conditions which prevent the patient from swallowing oral dosage forms **OR** which are contraindications to either itraconazole or terbinafine: _____

4. Has the patient failed therapy with fluconazole, or have a contraindication to oral fluconazole therapy? Yes No

5. Is the patient diabetic or immunocompromised? Yes No

6. Please list previous therapy prescribed for this patient for this diagnosis and reason(s) discontinued: _____

7. Select one: **Brand**

Generic (if available) – lowest copay

Lamisil 125 mg Granules Lamisil 187.5 mg Granules

ciclopirox 8% topical solution kit

CNL8 Nail Kit (ciclopirox) 8% topical solution

ciclopirox 8% topical solution

Penlac (ciclopirox) 8% topical solution

itraconazole 100 mg caps

Sporanox 100 mg capsules Sporanox 10 mg/ml oral solution

Quantity/30 days: _____

Directions: _____

8. Is this: An **initial** request? **OR** A **continuation** of therapy request?

Printed Name _____

Signature _____

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