AvMed

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-305-671-0200**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Topical Antifungals

❑ **Ertaczo® 2% cream** (sertaconazole)	❑ **luliconazole 1% cream** (generic Luzu®)	❑ **Mentax® 1% cream** (butenafine)
❑ **naftifine** (generic Naftin®) **1% cream**	❑ **naftifine** (generic Naftin®) **2% cream**	❑ **Naftin®** (naftifine) **1% gel**
❑ **Naftin®** (naftifine) **2% gel**	❑ **oxiconazole 1% cream** (generic Oxistat®)	❑ **sulconazole 1% cream/solution** (generic Exelderm®)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member AvMed #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

❑ Medication **MUST** be prescribed for treatment of an FDA approved indication **(provide diagnosis below)**:

_____

(Continued on next page)

- ❑ Member tried and failed **30 days of therapy** with **TWO** of the following medications **(verified by chart notes or pharmacy paid claims):**

❑ ciclopirox 0.77% cream/gel/suspension	❑ clotrimazole 0.05%/betamethasone 1% cream	❑ econazole 1% cream
❑ ketoconazole 2% cream	❑ nystatin 100,000 units cream/ointment/powder	❑ nystatin 100,000 units/triamcinolone 0.1% cream/ointment

Not all drugs may be covered under every Plan

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

*****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.*****