

State of Idaho, Division of Medicaid

**TOPICAL ANTIFUNGALS  
PRIOR AUTHORIZATION FORM**

*\*CONFIDENTIAL INFORMATION\**

**Phone: 1-208-364-1829**

*One drug per form ONLY – Use black or blue ink*

**Fax: 1-208-364-1864**

Patient Name: _____	Medicaid ID#: _____	D.O.B.: _____
Prescriber Name: _____	State License #: _____	Specialty: _____
Prescriber Phone: _____	Prescriber Fax: _____	
Pharmacy/Store#: _____	Phone: _____	Fax: _____

*Clotrimazole/betamethasone, econazole, Exelderm<sup>®</sup>, ketoconazole cream and shampoo, Naftin<sup>®</sup>, nystatin, nystatin/triamcinolone are preferred agents and will be approved for payment without prior authorization for eligible participants within the approved dosage quantities and age limits.*

*Ciclopirox cream and suspension, Ertaczo<sup>®</sup>, Loprox<sup>®</sup> gel and shampoo, Mentax<sup>®</sup>, Oxistat<sup>®</sup>, and Vusion<sup>®</sup> will be approved for payment only after documented failure of 1 preferred agent.*

**Medication Requested:**

<b>clotrimazole/betamethasone</b>	<b>NO PA REQUIRED</b>	<b>Naftin<sup>®</sup></b>	<b>NO PA REQUIRED</b>
<b>econazole</b>	<b>NO PA REQUIRED</b>	<b>nystatin</b>	<b>NO PA REQUIRED</b>
<b>Exelderm<sup>®</sup></b>	<b>NO PA REQUIRED</b>	<b>nystatin/triamcinolone</b>	<b>NO PA REQUIRED</b>
<b>ketoconazole cream and shampoo</b>			

<u>Drug</u>	<u>Strength</u>	<u>Dosing Instructions</u>
<input type="checkbox"/> ciclopirox cream and suspension	_____	_____
<input type="checkbox"/> Ertaczo <sup>®</sup>	_____	_____
<input type="checkbox"/> Loprox <sup>®</sup> gel and shampoo	_____	_____
<input type="checkbox"/> Mentax <sup>®</sup>	_____	_____
<input type="checkbox"/> Oxistat <sup>®</sup>	_____	_____
<input type="checkbox"/> Vusion <sup>®</sup>	_____	_____

**History of preferred agent:**

<u>Drug</u>	<u>Dates of Trial</u>	<u>Reason(s) for Failure</u>
_____	_____	_____

**Other pertinent information for review:**

*To ensure continuity of care, please make sure corresponding ICD-9 codes are submitted on professional office claims to Idaho Medicaid on a routine basis.*

**Prescriber Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*By signing, the prescriber agrees that documentation of above indication and medical necessity is available for review by Idaho Medicaid in patient's current medical chart.*

**For Medicaid Office Use Only**

Date: _____	RPh: _____	Tech: _____	PA#: _____
Approved _____	Denied _____	Comments: _____	

All current PA forms and criteria for use are available at: [www.medicaidpharmacy.idaho.gov](http://www.medicaidpharmacy.idaho.gov) (PA Criteria & Forms)