carolina complete health

Pharmacy Request for Prior Approval - Vusion

Recipient Information

1. Recipient Last Name:_____ 2. First Name:_____
3. Recipient ID #_____ 4. Recipient Date of Birth:_____ 5. Recipient Gender:_____

Payer Information

6. Is this a Medicaid or Health Choice Request? Medicaid: ☐ Health Choice: ☐

Prescriber Information

7. Prescribing Provider #:_____ NPI: ☐ *or* Atypical: ☐
8. Prescriber DEA #: _____
Requester Contact Information
Name:_____ Phone #:_____ Ext:_____

Drug Information

9. Drug Name: **Vusion** 10. Strength: _____ 11. Quantity Per 30 Days: _____
12. Length of Therapy (in days): ☐ up to 30 ☐ 60 ☐ Other:_____

Clinical Information

1. Is the patient 4 weeks of age or older? ☐ Yes ☐ No

2. Has the patient tried and failed on at least 2 different prescription products from this list within the past 60 days: nystatin cream, nystatin ointment, nystatin/triamconolone cream, nystatin/triamconolone ointment, or clotrimazole cream?
☐ Yes ☐ No

Please list products failed: _____

Please note – a quantity limit of 50 gm per 60 days is in place

Signature of Prescriber:_____ Date:_____
*Prescriber signature mandatory

Fax this form to: (877) 386-4695 Pharmacy PA Call Center: (833) 585-4309