carolina complete health

Pharmacy Request for Prior Approval
Topical Antifungal Agents: Vusion

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____

3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____5. Beneficiary Gender: ____

Prescriber Information

6. Prescribing Provider NPI #: _____

7. Requester Contact Information - Name: _____ Phone #: _____ Ext. _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____

11. Length of Therapy (in days): ☐ up to 30 days ☐ 60 Days

Clinical Information

1. Is the recipient at least four weeks of age? ☐ **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/triamcinolone cream, nystatin/triamcinolone ointment, or clotrimazole cream? ☐ **Yes** ☐ **No** **If YES, 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)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.